RA395
.U522
1947/48
S
pt.3

Library
National Institute of Health
Bethesda 14, Maryland

TIONAL HEALTH PROGRAM

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
EIGHTIETH CONGRESS
FIRST SESSION

ON

S. 545

A BILL TO COORDINATE THE HEALTH FUNCTIONS OF THE FEDERAL GOVERNMENT IN A SINGLE AGENCY; TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR THE FOLLOWING PURPOSES: TO EXPAND THE ACTIVITIES OF THE PUBLIC HEALTH SERVICE; TO PROMOTE AND ENCOURAGE MEDICAL AND DENTAL RESEARCH IN THE NATIONAL INSTITUTE OF HEALTH AND THROUGH GRANTS-IN-AID TO THE STATES; TO CONSTRUCT IN THE NATIONAL INSTITUTE OF HEALTH A DENTAL RESEARCH INSTITUTE; AND FOR OTHER PURPOSES

AND

S. 1320

A BILL TO PROVIDE A NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH PROGRAM

PART 3

JULY 9, 10, AND 11, 1947

Printed for the use of the Committee on Labor and Public Welfare

ibrary
ational Institute of Health
ethesda 14, Maryland

NATIONAL HEALTH PROGRAM

U.S. Congress. Senate. Committee on Labor and Public Welfare.
"

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

EIGHTIETH CONGRESS
FIRST SESSION

ON

S. 545

A BILL TO COORDINATE THE HEALTH FUNCTIONS OF THE FEDERAL GOVERNMENT IN A SINGLE AGENCY; TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR THE FOLLOWING PURPOSES: TO EXPAND THE ACTIVITIES OF THE PUBLIC HEALTH SERVICE; TO PROMOTE AND ENCOURAGE MEDICAL AND DENTAL RESEARCH IN THE NATIONAL INSTITUTE OF HEALTH AND THROUGH GRANTS-IN-AID TO THE STATES; TO CONSTRUCT IN THE NATIONAL INSTITUTE OF HEALTH A DENTAL RESEARCH INSTITUTE; AND FOR OTHER PURPOSES

AND

S. 1320

A BILL TO PROVIDE A NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH PROGRAM

PART 3

JULY 9, 10, AND 11, 1947

Printed for the use of the Committee on Labor and Public Welfare

FEB 19 '48
12/3/62 JB

UNITED STATES
GOVERNMENT PRINTING OFFICE
64431 WASHINGTON : 1948

RA 395
.U522
1947/48
S
pt. 3

COMMITTEE ON LABOR AND PUBLIC WELFARE

ROBERT A. TAFT, Ohio, *Chairman*

GEORGE D. AIKEN, Vermont
JOSEPH H. BALL, Minnesota
H. ALEXANDER SMITH, New Jersey
WAYNE MORSE, Oregon
FORREST C. DONNELL, Missouri
WILLIAM E. JENNER, Indiana
IRVING M. IVES, New York

ELBERT D. THOMAS, Utah
JAMES E. MURRAY, Montana
CLAUDE PEPPER, Florida
ALLEN J. ELLENDER, Louisiana
LISTER HILL, Alabama

PHILIP R. RODGERS, *Clerk*

SUBCOMMITTEE ON HEALTH

H. ALEXANDER SMITH, New Jersey, *Chairman*

JOSEPH H. BALL, Minnesota
FORREST C. DONNELL, Missouri

JAMES E. MURRAY, Montana
CLAUDE PEPPER, Florida

CONTENTS

I. Alphabetical List of Witnesses

Page
Carey, James B., secretary-treasurer, Congress of Industrial Organizations 1351
Cruikshank, Nelson H., director, social insurance activities, American Federation of Labor 1319
Davis, Michael M., Ph. D., chairman, Committee for the Nation's Health, Inc., New York, N. Y. 1548
Hansen, Horace R., general counsel, Cooperative Health Federation of America, St. Paul, Minn 1384
Lasker, Albert D., president, Albert and Mary Lasker Foundation, New York, N. Y. 1437
Lenroot, Katharine, Chief, Children's Bureau, Social Security Administration 1286, 1306, 1317
Louchheim, Joseph H., executive director, Committee for the Nation's Health, Inc., New York, N. Y. 1543
Miller, Hon. Watson B., Administrator, Federal Security Agency 1130
Mitchell, William L., Acting Commissioner for Social Security, Social Security Administration 1286, 1310, 1317
Parran, Dr. Thomas, Surgeon General, United States Public Health Service 1241
Poss, Edward F., chairman, board of grand trustees, and past grand worthy president, Fraternal Order of Eagles, Springfield, Ohio 1123

II. Chronological List of Witnesses

Wednesday, July 9, 1947:
- Edward F. Poss, chairman, board of grand trustees, and past grand worthy president, Fraternal Order of Eagles, Springfield, Ohio 1123
- Hon. Watson B. Miller, Administrator, Federal Security Agency 1130
- Dr. Thomas Parran, Surgeon General, United States Public Health Service 1241
- William L. Mitchell, Acting Commissioner for Social Security, Social Security Administration 1286, 1310, 1317
- Katharine Lenroot, Chief, Children's Bureau, Social Security Administration 1286, 1306, 1317

Thursday, July 10, 1947:
- Nelson H. Cruikshank, director social insurance activities, American Federation of Labor 1319
- James B. Carey, secretary-treasurer, Congress of Industrial Organizations 1351
- Horace R. Hansen, general counsel, Cooperative Health Federation of America, St. Paul, Minn 1384

Friday, July 11, 1947:
- Albert D. Lasker, president, Albert and Mary Lasker Foundation, New York, N. Y. 1437
- Joseph H. Louchheim, executive director, Committee for the Nation's Health, Inc., New York, N. Y. 1543, 1670
- Michael M. Davis, Ph. D., chairman, Committee for the Nation's Health, Inc., New York, N. Y. 1548

III. List of Statements and Communications

Cruikshank, Nelson H., director, AFL social insurance activities, declaration of American Federation of Labor in re social insurance at its sixty-fifth convention 1322

Page

Carey, James B., secretary-treasurer, Congress of Industrial Organizations, letter of, to Philip R. Rodgers, committee clerk, enclosing list of names of foreign officials with whom he discussed compulsory insurance 1372

Davis, Michael M., Ph. D., chairman, Committee for the Nation's Health, Inc., New York, N. Y., insertions of:
  Chart entitled "Medical Expenditures in Relation to Family Income" 1609
  Chart entitled "And as a Percentage of Total Family Income" 1609
  Public Health Reports, vol. 62, No. 11, March 14, 1947, Health Insurance Programs and Plans of Western Europe 1584

Donnell, Hon. Forrest C., a United States Senator from the State of Missouri, insertions of:
  American Historical Association, booklet prepared by, for United States armed forces, entitled, "Is Your Health the Nations' Business?" 1629
  Association of American Physicians and Surgeons, resolution of, in opsition to S. 1320, adopted at meeting in Chicago, Ill., on June 27–28, 1947 1547
  Committee for the Nation's Health, Inc.:
    Press release of, dated July 10, 1947, entitled, "Thurman Arnold Charges AMA With Monopolistic Practices" 1486
    Statement prepared by, entitled, "Brief History of Health Insurance in United States" 1673
  Eiseman, Robert, and Goldman:
    Data on, derived from report of the Special Committee on Un-American Activities of the House of Representatives, Seventy-eighth Congress 1661
    Film strip by, entitled, "Medical Insurance—a Pathway to Health" 1662
  House Report No. 786, Eightieth Congress, First Intermediate Report of the Subcommittee of the Committee on Expenditures in the Executive Departments Authorized To Investigate Publicity and Propaganda of Federal Officials in Formation and Operation of Health Workshops 1196
  Mitchell, William L., Acting Commissioner for Social Security, Social Security Administration, statement of experience 1316
  Newspaper clippings as follows:
    Christian Science Monitor, Boston, Mass.:
      April 12, 1947, Compulsory Health Insurance Costs Soar in New Zealand 1578
      January 4, 1947, Hiatus in Sickness Insurance—Favorable Evidence or Praise Found Lacking in Areas Where System Is Adopted 1582
    Daily Worker, New York, N. Y., June 2, 1947, New Film Strip Dramatizes Need for Health Insurance 1668
  Shearon, Marjorie, Ph. D., letter to, from J. P. S. Jamieson, M. D., Nelson, New Zealand, in re New Zealand social-security medical services 1580

Hansen, Horace R., general counsel, Cooperative Health Federation of America, St. Paul, Minn., insertion of:
  Cooperative Health Federation of America:
    Board of directors, statement of, entitled, "Specific Provisions That Must Be Incorporated in National Health Legislation If Supported By Consumer-Sponsored Voluntary-Prepayment Organizations * * *" 1386
    Articles of incorporation and bylaws 1408
  Cooperative League of the United States of America:
    Resolutions adopted by, at cooperative congress, Columbus, Ohio, September 9–11, 1946, in re health legislation 1385
    Resolution Unanimously Adopted by Fifteenth Biennial Congress, Cooperative League of the United States of America, Columbus, Ohio, September 9–11, 1946 1388
  Cooperative Health Federation of America, George W. Jacobson, secretary-treasurer, letter of, to Dr. Morris Fishbein, editor, Journal of the AMA, Chicago, Ill., setting forth statement of principles and aims of the federation 1390

Hansen, Horace R., general counsel—Continued Page
  Cooperative League of the United States of America, and Cooperative Health Federation of America, H. Jerry Voorhis, executive secretary, letter of, to the committee, authorizing Mr. Hansen to speak for the league before the committee 1388
Miller, Hon. Watson B., Administrator, Federal Security Agency, insertions of:
  Letter of, to Senator Taft, reporting on S. 545 1144
  Letter of, to Senator Taft, reporting on S. 1320 1152
  Office memo from Zilpha C. Franklin, director of information, Federal Security Agency, to Mr. Watson B. Miller, Administrator, in re request for participation in health workshop 1204
Murray, Hon. James E., a United States Senator from the State of Montana, insertions of:
  Chavez, Hon. Dennis, a United States Senator from the State of New Mexico, statement of, in re health legislation 1538
  Committee for the Nation's Health, Inc., letter to, from Samuel Robert, ERG Productions, New York, N. Y., requesting information in re annual income of physicians 1692
  Cruikshank, Nelson H., director, AFL social insurance activities, article of, Playing Politics With Health 1214
  Fact sheet 1, Health Insurance, compiled by office of Senator Murray 1270
  Fact sheet 2, Health Insurance, compiled by office of Senator Murray 1272
  Louchheim, Joseph H., executive director, Committee for the Nation's Health, Inc., letter of, to—
    Senator Murray, amplifying Louchheim's testimony 1690
    Samuel, Robert, ERG Productions, New York, N .Y., in re annual income of physicians 1690
  McGrath, Hon. J. Howard, a United States Senator from the State of Rhode Island, statement of, in re health legislation 1516
  Medical Annals, November 1946, excerpt from, The Lady Who Knows 1213
  Newspaper clipping from the Post-Dispatch, St. Louis, Mo., Jan. 19, 1947, Lobbyists Offer of Research Aid Against Health Bill Disclosed—GOP Employee Working on Measure for Senators Says She Rejected Proposal of Physicians' Agent 1210
  Raymond Rich Associates:
    Letter of, to Dr. R. L. Sensenich, South Bend, Ind., in re public relations of the American Medical Association 1525
    Note of, with regard to the National Physicians Committee 1534
    Report on Public Relations to the Trustees of the American Medical Association, May 24, 1947, by Raymond Rich Associates 1526
    Telegram of, to the speaker of the house of delegates of the American Medical Association in re resignation of firm from public relations work for the association 1524
  Rocky Mountain Medical Journal, October 1946, article of, Dr. Shearon Addresses Colorado Society 1213
  Shearon, Marjorie, Ph. D.:
    Letter of, to members of health and medical professions and to others interested in defeating plans for establishment of State socialism in the United States 1207
  Statement of, Announcing Establishment of the Shearon Medical Legislative Service, Washington, D. C., July 1, 1947 1208
  Subcommittee Report No. 5 of Senate Committee on Education and Labor, Seventy-ninth Congress, pursuant to Senate Resolution 62 in re health insurance 1487
  Taylor, Hon. Glen H., a United States Senator from the State of Idaho, statement of, in re health legislation 1535
  Wagner, Hon. Robert F., a United States Senator from the State of New York, statement of, in re health legislation 1514
Pepper, Hon. Claude, a United States Senator from the State of Florida, insertions of:
  Arnold, Thurman, Washington, D. C., letter from, to Dr. Channing Frothingham, chairman, Committee for the Nation's Health, Inc., New York, N. Y., in re S. 545 1428
  Kiplinger's Magazine of April 1947, article entitled "Health Means Plans and Dollars—We Must Find a Way To Meet Our Challenging National Medical Problem 1431

Pepper, Hon. Claude, a United States Senator, insertions of—Continued Page
  Shearon, Marjorie, Ph. D., Chevy Chase, Md., letter of, addressed to her readers, in re discontinuance of her news releases 1285
  Supreme Court of the United States, decision of, in re the cases of *American Medical Association* v. *The United States of America*, and *The Medical Society of the District of Columbia* v. *The United States of America* 1222
  United States Court of Appeals for the District of Columbia, decision of, in re the *American Medical Association* v. *United States of America*, and *Medical Society of the District of Columbia* v. *United States of America* 1227
  Vessels, Alma, R. N., executive secretary, National Association of Colored Graduate Nurses, Inc., New York, N. Y., letter of, to Senator Murray in favor of S. 1320 1429
Parran, Dr. Thomas, Surgeon General, United States Public Health Service, statement of, The Need For and the Costs of Additional Medical Personnel and Facilities 1279
Potofsky, Jacob S., general president, Amalgamated Clothing Workers of America, and member of the executive board, Congress of Industrial Organizations, statement of, in re health legislation 1381
Smith, Hon. H. Alexander, a United States Senator from the State of New Jersey, insertions of:
  Lull, George F., American Medical Association, Chicago, Ill., letter of, to Senator Smith, in re Thurman Arnold's letter to Dr. Frothingham 1430
  Robins, R. B., M. D., national committeeman, Democratic National Committee, Camden, Ark., letter to Gael Sullivan, executive director, Democratic National Committee, Washington, D. C., in re compulsory health legislation 1434
  Woll, Matthew, second vice president, American Federation of Labor, telegram of, addressed to Philip R. Rodgers, committee clerk, authorizing Nelson H. Cruikshank to testify before the committee in behalf of the American Federation of Labor 1320

IV. List of Charts and Graphs

Agency participation in "health workshop" program Faces 1202
The costs of medical care are unevenly distributed 1488
The lower the income, the more sickness and the less care 1489
Present coverage of voluntary plans 1491
The twenty-five percent:
  Type of services received 1493
  Type of plan 1493
All Blue Cross members get hospitalization 1495
Medical services received 1498
Medical society plans, 1945 1498
Services offered by medical care prepayment plans Faces 1500
Who buys prepayment 1503
Hospital insurance poll, Rochester, N. Y. 1505
American family incomes 1505
Turn-over in a voluntary medical care plan, rural Ohio 1506
Those who used the plan most remained members 1506
How tax-subsidized voluntary health insurance worked in six rural counties 1508
United States opinion on costs of medical care:
  I 1510
  II 1511
  III 1511
Medical expenditures in relation to family income 1609
Medical expenditures as a percentage of total family income 1609

NATIONAL HEALTH PROGRAM

WEDNESDAY, JULY 9, 1947

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 9:30 a. m., in the committee room in the Capitol Building, Senator H. Alexander Smith, presiding.

Present: Senators Smith (presiding), Donnell, Murray, and Pepper.

Senator Smith. The committee will please come to order. Our first witness this morning is Mr. E. F. Poss, representing the Fraternal Order of Eagles, Springfield, Ohio. We will be glad to hear you, Mr. Poss.

STATEMENT OF EDWARD F. POSS, TOLEDO, OHIO, CHAIRMAN, BOARD OF GRAND TRUSTEES, AND PAST GRAND WORTHY PRESIDENT, FRATERNAL ORDER OF EAGLES

Mr. Poss. Mr. Chairman and gentlemen, I should like to say as a representative of the Fraternal Order of Eagles, that I appear here not for the purpose of directing or endorsing any particular movement, but rather for an expression of the 1,250,000 Eagles. As chairman of the board of grand trustees and former national president of the Fraternal Order of Eagles, I am appearing before your committee on behalf of an organization which has a membership of 1,250,000 representative Americans, a cross section of our population. Our order has aeries or lodges in approximately 1,400 communities. It is the largest benefit paying organization in the world.

In the 49 years of its existence, the Fraternal Order of Eagles has campaigned for measures that contributed to human welfare. Perhaps some of you gentlemen are familiar with its record. Back in 1921 the Eagles launched a crusade for State old-age pension laws. We regarded the poorhouse as an institution not in keeping with the dignity of Americans who had reached an advanced age without the proper means to maintain themselves. We felt that the American way was to provide cash payments so that our senior citizens could look after their own needs and retain their self-respect. The State old-age pension movement was started in Montana by an Eagle legislator, who received the full support of our order, with the result that the first State old-age pension bill was enacted into law. Practically every State old-age pension law can be traced to Eagle initiative and support.

Even in those early days, the Eagles felt that State old-age pensions were not the complete answer. Old-age pensions removed the stigma of the poorhouse, but they still left the recipients as wards of the State. The Eagles foresaw the time when American workers would contribute to their own security and participate in a retirement plan in which they would earn their benefits. That kind of program was in keeping with the pride and desire of the individual American. Thus the Eagles joined the movement for the national Social Security Act back in 1921. Our order spent more than a million dollars on an educational campaign in behalf of such legislation. Two national leaders of our order served on the advisory committee that drafted the Social Security Act. Senator Robert Wagner, a member of our order, introduced the bill in the Senate, and Representative David Lawrence, also a member of the order, sponsored it in the House. In acknowledgment of the services of the Eagles in behalf of this legislation, the late President Roosevelt, a life member of the order, invited Eagle representatives to witness the signing of the act, and presented them with a pen. A member of our order served on the first Social Security Board. We believe that our early faith in the sound principles of social security and the workability of a Government system of social insurance, based on a contributory plan, has been well justified. We are proud of the part our order has had in the enactment of this act, and we are campaigning for extension of social security to include the 20,000,000 Americans not now eligible to participate in benefits.

The Eagles campaigned for other worthy social legislation. The order was a leader in the fight for legislation to bring some degree of happiness into the lives of dependent mothers and provide them with assistance in the task of rearing their children when their husbands were taken by death. The first mothers' pension law in the United States was drafted by a Kansas City Eagle and passed in Missouri with the support of our order.

Senator DONNELL. Was that Mr. Conrad Mayham?

Mr. POSS. No; that was Judge Porterfield.

Senator DONNELL. The man who was at the head of it was Conrad Mayham, president of the chamber of commerce in Kansas City?

Mr. POSS. That is right. Our order was a leader, too, in the early movement for workmen's compensation. It fought for the first workmen's compensation law in America, the Wisconsin law, which was drafted by an Eagle and backed by his fraternity. Economic misfortune has been responsible for a great share of human misery and unhappiness, often due to no fault of the victims. As a fraternity we have tried to ease the burdens and impress upon our fellow citizens the common obligation we all have to lighten the misfortune which may come to any of us in the course of our daily living.

The Fraternal Order of Eagles is sponsoring programs that promote the general welfare. It has established national commissions to further these programs. The order is actively engaged in combating juvenile delinquency, in advancing child health and child welware, in stimulating full employment, in rehabilitating our veterans, and aiding our handicapped and elderly citizens.

One of our primary concerns is child health. One of the important program slogans of the Eagles is "A chance at a real childhood for every child." Our order has given more than lip service to such an objective. It established a National Youth Guidance Commission, which has aided aeries in many communities to promote wholesome undertakings for the young-youth centers, local youth guidance institutes, community youth councils, athletics and the like. In 1941 the Eagles at a cost of $160,000 erected a dormitory for Father Flanagan's Boys Town.

About 2 years ago the Eagles set up a National Child Health Commission, and some of the results of this work are already apparent. Some of our aeries have set up well-baby clinics in cooperation with local health authorities, and have made available medical facilities to examine children and advise mothers on diet and the healthful upbringing of their children.

The Fraternal Order of Eagles has wholeheartedly supported health legislation which it believes will contribute materially to an improvement in the health of our Nation. Our fraternity endorsed the Federal school-lunch appropriations to the States, and scores of our aeries passed resolutions advocating such aid. Our order, too, endorsed the maternal and child welfare bill, sponsored by Senator Pepper, because it feels that the services proposed, medical and hospital care when children are sick, school-health services and dental care and child-guidance clinics, are essential for the well-being of our future citizens.

The Fraternal Order of Eagles favors certain provisions of the National Health Act of 1947, S. 545, sponsored by Senators Taft, Smith, Donnell and Ball. It regards the proposed legislation as a forward stride in solving some of the health problems that challenge solution. Certainly, the proposed expenditure of $200,000,000 a year to provide general health, hospital and medical services for families and individuals with low incomes is a real approach to aiding the welfare of the underprivileged. Our order endorses the proposed establishment of a national health agency and the program this agency would administer. We are glad to see two objectives included among the proposed work of the agency, because they are objectives which our order has gone on record with its support. I refer to "the promotion of maternal, prenatal and child care, and the study and dissemination of information on child growth, development, and nutrition" and to "the training and rehabilitation of persons vocationally handicapped because of permanent disability with the objective of placing such persons in remunerative employment."

Our order, at its 1946 national convention, pointed to this need for vocational training both for our disabled war veterans and the victims of industrial accidents. The Eagles National Commission on Stimulation of Employment, in its report to the convention stated:

> Too often have the various State agencies, charged with the responsibility of caring for injured workers, failed to properly discharge their trust. Too often have crippled workers been relegated to the human scrap heap and the conscience of legislatures and public officials salved by the payment of a pittance in money. The injured industrial worker often needs to be retrained and rehabilitated so that he may return to work and earn his own livelihood by the best utilization of his personal talents.

I have just quoted in part from the report of the Eagles' National Commission on Stimulation of Employment.

Other provisions of S. 545 are formidable assaults upon ill health. The distribution of funds for dental care, cancer control, a National

Institute of Dental Research, a survey of health and medical care resources, a dental care survey, are appropriations which our order believes will appreciably advance the public health services.

The means by which these funds would be allotted to the States—the grants-in-aid principle—is the guiding principle of the Social Security Act. Our order indorses such use of Federal funds. In fact, in our support of the Social Security Act, we stressed the soundness of Federal grants to States to provide for the public assistance of needy persons.

The Fraternal Order of Eagles wholeheartedly subscribes to the statement in the National Health Act of 1947 which would establish as the policy of the United States Government—

> to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public health services to every individual regardless of race or economic status.

Our order further believes that a Federal health program to be adequate to meet the needs of all economic groups in our population should take into account the necessity for establishment of a system of national health contributions to the Social Security System on the part of employers and employees to pay for cash disability benefits and medical cost reimbursements.

We must recognize the fact that even if adequate provisions are made for medical services for low-income families and the needy, there will still remain millions of Americans upon whom illness will fall as a crushing economic disaster. The Census Bureau recently published figures which revealed that the median income for American families living under one roof was $2,378 in 1945. Presumably these are families which cannot be classified as low-income groups, but it is very evident that they must struggle to maintain even a fair standard of living. Such families have no income to tide them over to meet medical expenses and ordinary family requirements when the wage-earner takes sick. Our order believes that a system of national health insurance is necessary to provide protection for vast numbers of American families.

When the Fraternal Order of Eagles held its 1945 national convention, it went on record for endorsement of "the general aim and objects" of the then pending Wagner-Murray-Dingell bill which provided for cash benefits for temporary and permanent disability. When I appeared before your committee last year relative to the national health bill, S. 1606, I stated that certain provisions of the Wagner-Murray-Dingell bill were in line with the long time fundamental policies and program of the Eagles, and that the same could be said for certain provisions of Senate bill 1606. This also holds true for Senate bill 545 or the national health bill of 1947. The Fraternal Order of Eagles endorses its general objectives and provisions. It conforms with many of the objectives of the Eagles in the national health field. But our order feels now, as it has in the past, that a system of national health insurance should be included in any approach to solution of our national health problem.

Last year before your committee, I made a statement on the Eagle position that was incorporated in the report of our order's National Old Age and Social Security Commission and unanimously adopted by the 1946 annual convention. I should like to restate this position.

> There is at least as much reason for using social insurance to protect workers against sickness as there is in using it to provide replacement income during periods of unemployment. The need for providing wage earners insurance against wage loss when they are sick or disabled is an apparent one. Certainly the Eagles who fought for workmen's compensation laws to protect against work-connected disabilities could be expected to enthusiastically support a plan to provide cash benefits for disability identical with those given workers during times of unemployment. The loss of income during periods of sickness—enforced idleness—is as great a menace to those who work for a living as are the costs of medical care involved in such sickness.
>
> Obviously a system of temporary and permanent disability benefits that made no provision for at least partial reimbursement of medical and surgical expenses would have serious shortcomings. If all Americans are to be given some minimum insurance against all common economic hazards, the crushing burden of unexpected medical and hospital expenses incident to illness must be redistributed through some form of social insurance. Particularly in lower income and many-children families, doctor and hospital bills can eat away a family's lifetime savings.
>
> Our organization represents a cross section of America. Undoubtedly there are thousands of our members who might think this statement of policy a very conservative and somewhat negative one. I believe that the average Eagle, who is an average American, favors that all of us will help foot the Nation's doctor bills instead of letting the unlucky or sickly one take the brunt of the burden. But I doubt that the average Eagle or average American is equally enthusiastic about having doctors and nurses become direct or indirect Federal employees, paid by the Government. He wants free choice of a physician, but not necessarily free choice of Government-employed physicians.
>
> To put it differently, I'd venture the opinion that he wants insurance against medical expense provided—but not necessarily the medical care itself provided.

In conclusion, I should like to summarize the principal provisions advocated by the Fraternal Order of Eagles in a national health insurance plan.

1. Cash benefits covering wage loss during periods of temporary or permanent disability, identical with those now provided for wage loss during periods of unemployment.
2. Cash reimbursements to workers for major hospital, surgical, and medical expenses for themselves and their families.
3. Increased contributions from employer and employee to the social-security system, on the part of employers and employees, to pay for such cash disability benefits and medical cost reimbursements.
4. A guaranty of the independence of the medical profession, with no limitation on the average American's right to choose and pay his own family doctor or dentist, using social insurance only to guarantee his ability to do so.
5. Continued reliance on the fundamental principles of the original Social Security Act—Federal Government's grants-in-aid to States for the public assistance of the needy, and social insurance to give all Americans protection against the major economic hazards of life.

This program is a contributory system of protection against the economic hazards of illness, and provides for the dignity of the patient and the independence of the medical profession. It is practical and economically sound. The Fraternal Order of Eagles believes that such a program will eliminate a major fear in the daily life of the average family, the haunting fear of sickness-induced poverty. We believe that such a program will be a distinct contribution on the part of Government to the welfare and happiness of millions of our citizens. Thank you very much, gentlemen.

Senator SMITH. We very much appreciate your statement, Mr. Poss. I have just one question I would like to ask.

I think you have made it very clear in your statement, but your whole theory of the plan that you advocate contemplates an over-all tax, you might say, on everybody for contributions to the fund, the same kind of tax we have for Social Security today?

Mr. Poss. Yes.

Senator Smith. You add this to that tax, but instead of giving service for the money paid in the way of medical service, you simply give compensation in dollars to the person, who could buy their own medical service? Is that the theory? You say here:

> I venture the opinion that he wants insurance against medical expenses but not necessarily the medical care itself provided.

Mr. Poss. Here is what we mean by that: We mean that the insurance be set in such a way that the recipient of the service will be free to call the doctor of his choice. The compensation will be paid to him and he in turn compensates the doctor, rather than to have a list of doctors or a group of doctors who will be paid by the Surgeon General of the United States or by the Government. It will be given to the individual, and the individual receiving the aid will have the right to choose any doctor. Mrs. Brown may have an affection for Dr. Jones, who can best administer to her baby. Well, she will call Dr. Jones. Then the check will be sent to Mrs. Brown and she will pay the doctor. That will eliminate the stigma of socialized medicine. It is, we believe, the real democratic way of operation—operating exactly the same as an insurance company.

Senator Smith. You probably have in mind what is called the fee for service system, their paying the doctor. We have had some discussion here to the effect that there are three ways to pay doctors' fees for services: The so-called "capitation" method, wherein the doctor is paid so much per patient taken care of; the over-all fixed salary method paid by the State or Federal Government. Your plan will leave the doctors where they are now, and you simply give dollar benefits to people who are insured under this system, so they can go and employ their own doctor and pay whatever fee the doctor charges?

Mr. Poss. Yes; the insurance plan will be a guaranty of medical service to them, and likewise pay for the doctor, but will not confine them to the selection of a Government-proposed doctor. They would have freedom of choice of the doctor whom they wanted to administer to them. I am of the opinion that the application of the law will bring out a plan and a program of how eventually the doctor will be paid. I suspect that over a period of years there might be a general plan of a certain sum for such service. I am just guessing at that. I don't know, but it would appear to me that eventually that would happen.

Senator Smith. I have in mind such plans as the Blue Cross service plan for hospitalization by insurance, and the Blue Shield, and so on, those different plans that are being developed by the medical profession itself to try to help people to get proper insurance of medical care.

Mr. Poss. I have absolutely no argument with them, except we feel that there are too many who do not come within the scope of those plans.

Senator Smith. Of course, that is one of the things we are discussing, how we can get over-all coverage in some adequate way. In S. 545, which I am glad to see you support the principles of, we are thinking in terms of something like that where each State will be challenged to come out with its own plan and give us the benefit of 48 experiments going on continuously, and get the best plans from the States to meet the problem. I think we are all in sympathy with what you are driving at here, to take care of the needy. It is just a question of the best way to do it.

Mr. Poss. I want to leave this impression with you gentlemen, that by no stretch of the imagination do I appear here as trying to set up a plan or program. We are here to advocate the principles of health insurance; 1,250,000 Eagles are definitely interested in this program, and we are willing and anxious to go along with any program that will get the job done. We have no political axes to grind, as you understand, Senator.

Senator Smith. I understand that. Senator Donnell, have you any questions?

Senator Donnell. Mr. Poss, you mentioned in your statement that you appeared before the Committee on Education and Labor last year?

Mr. Poss. That is right.

Senator Donnell. And I think this is your second trip to Washington?

Mr. Poss. Yes.

Senator Donnell. At your own expense or that of your order?

Mr. Poss. The order pays it.

Senator Donnell. But you have come here because of your interest in this great subject matter, and have endeavored to give us the views of your organization?

Mr. Poss. That is right.

Senator Donnell. And your organization has been very active in this matter for some years?

Mr. Poss. That is right.

Senator Donnell. That is all.

Senator Smith. Do you have any questions, Senator Murray?

Senator Murray. I have only a very few questions. I would join with Senator Donnell in expressing my appreciation of your appearance here this morning, and I am very sorry that I was not able to be present when you were here a short time ago. I aided in every way to make it possible for you to come here this morning.

Senator Donnell. I did not mean in my questions the slightest criticism. I was simply endeavoring to bring out the fact that the witness was very much interested in the matter and I am sure we all appreciate his being here.

Senator Murray. Yes; I appreciate what the Senator says. I merely wish to reiterate what he has said, because I know this gentleman has taken a very deep interest in the problem, and has come here at a great deal of inconvenience for the second time.

I understand, Mr. Poss, that you do not regard this bill, S. 545, as a substitute for a national health insurance?

Mr. Poss. No, sir.

Senator Murray. It is merely a stopgap? Isn't that it?

Mr. Poss. That is right. I think we have set forth plainly in our program what we stand for, and we are here to assist, in any way we can, this program.

Senator MURRAY. You say your order feels now, as it has in the past, that national health insurance should be included in any approach to the solution of our national health program?

Mr. POSS. That is right.

Senator MURRAY. S. 545 only provides $200,000,000, which would be absolutely insufficient to provide any relief for the millions of people who are in need of health care and are not able to have it at this time.

Mr. POSS. I think that is true. I think I have indicated that in my discussion. I said the Fraternal Order of Eagles favors certain provisions, and further on I think I said that these are steps in the right direction, but we are far removed from the ultimate solution.

Senator MURRAY. But you would not recommend the extension of that system provided in S. 545 for the taking care of total needs of the people?

Mr. POSS. Definitely not.

Senator MURRAY. That would be socialized medicine in an extreme way?

Mr. POSS. Yes, I think so.

Senator MURRAY. Because the Government there would be paying the entire cost of the medical care, and it would avoid entirely the program that we are suggesting with reference to an insurance system?

Mr. POSS. Yes, sir.

Senator MURRAY. I think that is all.

Senator SMITH. Thank you very much, Mr. Poss. We are very glad to have you with us.

Mr. POSS. Thank you, gentlemen.

Senator SMITH. Next on our list this morning is Mr. Watson B. Miller, Administrator of the Federal Security Agency. We are glad to see you this morning, Mr. Miller.

STATEMENT OF HON. WATSON B. MILLER, FEDERAL SECURITY ADMINISTRATOR, WASHINGTON, D. C.

Mr. MILLER. I am glad to be here, Senator.

Senator SMITH. I think we know who you are, Mr. Miller. I think you are well enough known that we do not need to ask you for a biographical sketch of the witness.

I have here a statement marked, "Statement before the Senate Labor and Public Welfare Committee," and also I have here a letter which is addressed by you, apparently, to Senator Taft, and I am interested to know are they both relative to the same subject?

Mr. MILLER. One, Mr. Chairman, is the customary report upon one of the two measures under examination here, and I have no doubt that the second one constitutes my own statement before the subcommittee, rather than the formal comment upon the bill.

Senator SMITH. You may proceed in your own way, Mr. Miller.

Mr. MILLER. Mr. Chairman and gentlemen, we in the Federal Security Agency deeply appreciate your invitation to participate in these hearings on S. 545 and S. 1320. The importance of such hearings cannot be overestimated. They help us all to see the basic issues more clearly. And through indicating the gap between what can be done and what is being done to provide our people with the truly wonderful kind of medical care we have in our country, such hearings stimulate public discussion and study of the problems.

Whether or not any major health legislation be enacted in this session, very substantial progress has been made as a result of these and last year's hearings. I say this quite earnestly, because I feel that these public exchanges have disclosed substantial and important areas of agreement, which I like to think of in the light of the following five considerations.

FUNDAMENTAL AREAS OF AGREEMENT

The people as a whole have:

1. Recognized a Federal interest, to be backed by a Federal financial concern, in the health of each person in our country.
2. Agreed upon the necessity for broadening the availability of medical care and health services through new means and approaches.
3. Accepted the wisdom of overcoming shortages of personnel and facilities as rapidly as may be practicable.
4. Asserted the wisdom and necessity of adopting some prepayment method of meeting the costs of medical care.
5. Agreed upon the wisdom and necessity of decentralizing the administration of any national-health program.

FURTHER FUNDAMENTAL PROPOSITIONS

In addition to these fundamental areas of agreement, certain other propositions are, I believe, equally valid: That large numbers of otherwise self-supporting people are unable to secure all the medical care and health services which they need both to prevent and to alleviate illness; that this inability is in large measure due to the fact that a great many people cannot afford essential medical care, in terms of their general expenses for just living; that Abraham Lincoln's reflection is applicable:

> * * * the legitimate object of Government [is] the doing for a community of people whatever they need to have done, but cannot do at all or cannot do so well for themselves in their separate and individual capacities—

and therefore that the Federal Government must devise a system through which medical and health care may be conveniently and effectively financed.

On the basis of these observations, we believe that health insurance is the most effective means by which our people can meet their health needs.

Senator SMITH. When you say "health insurance" there do you mean compulsory health insurance?

Mr. MILLER. Yes, Senator, so far as it is possible to develop such a plan. That conviction is based upon a growing and increasingly successful experience in the field of social insurance during the last 10 years.

Senator DONNELL. You mean in other countries?

Mr. MILLER. In this country, in the segments of social insurance. I do not have the competence to offer reflections upon the systems involved in other countries.

Senator DONNELL. We do not have any compulsory health insurance in this country, do we, Mr. Miller?

Mr. MILLER. So far as I know, we have not—at least, there may be some in some municipalities, but if there are, I am not aware of them.

Senator DONNELL. There are some statutes up in one of the New England States, Rhode Island, are there not, on a cash sickness benefit basis?

Mr. MILLER. I am not advised of that, Senator. It is quite likely that there may be.

Senator SMITH. Let me just develop that a little further. Your thought of a compulsory health insurance plan would be a compulsory health insurance tax like the social-security tax, added to the present percentage, whatever it may be, for social security?

Mr. MILLER. I think the national lawmaking body should develop the manner in which the money should be raised, but I favor an individual prepayment system which would bring about payment within the capacity of most people against the contingency of illness and necessity for medical care. I have made a good deal of inquiry around in the States as to the difference in the attitude of people toward receiving the monthly benefits under old age and survivors' insurance, and those who receive public assistance benefits because of advancing years, and so on, to which they contribute nothing, and I am told generally that the former group seems to have more self-respect and self-reliance and less feeling of dependency on the community at large.

Senator SMITH. Then whether your sick fund is to be raised by pay-roll deductions or any other scheme that might be devised, however the fund is raised, do you contemplate that that would be distributed in cash to the individuals receiving the benefit, in which instance he would be required to attend to his health needs with that many dollars, so that the obligation of the State would be satisfied by that route? Or would you have some form of organization of your medical profession in order to meet the responsibility assumed by the Government in asking individuals to make that deduction from his pay roll?

Mr. MILLER. I think the most convenient and effective plan would be disclosed by experimentation, Senator Smith. I am myself a member of one of the health groups, and I value my membership in it very highly.

(Discussion off the record.)

Senator SMITH. But you have in mind that possibly we might have to have some regulation to provide that the person rendering the service would be compensated from the funds dedicated to this purpose?

Mr. MILLER. Yes; the system would have to provide for payment for hospitals and doctors and nurses and others. Many millions of American men, women, and children have gone down into the shadow of the valley of death with our fine physicians. We have confidence in them. I myself am very proud of American medicine, and I would not consciously do it any harm. Conversely, confidence ought to flow the other way. Our fine physicians should have some confidence in their people and their Government to protect the fine physicians and the developments, the astonishing developments of medicine and their application, particularly in the last decade.

Senator SMITH. I would like to get more thoroughly just what your position is. As I get it, you start with the compulsory plan rather than the theory of S. 545, which aims to start in a slower way. I have never had any objection to the compulsory plan. I am told that California is interested in that idea, and I say let them try it. I am not prepared to say yet that we should adopt the compulsory plan before we determine how we are going to have that fund applicable.

Mr. MILLER. No plan can emerge from a cloud on top of the mountain full-fledged and effective to maximum possibilities overnight. Of course, we are going to make a trial run and benefit by experience as we do in our other programs in the Federal Security Agency, and profit by experiences of success or failure.

Senator SMITH. You think we are ready to put this program under over-all social security and increase the pay roll deductions and say we are going to add to the benefits now given by Social Security a complete health coverage?

Mr. MILLER. I do, Senator, and I believe that as fundamentally and soundly as any conviction that I have can be. A 100 percent try may justify a lack of 100 percent success at the initiation of any program of this kind. That is true of other laws you have passed.

Senator SMITH. You prefer that rather than the slower trial and error method of giving the States the opportunity to work out their problems and give us the benefit of their experience?

Mr. MILLER. I shall make some reference to S. 545 as I go along.

Senator SMITH. Proceed, Mr. Miller. I shall not interrupt you any more.

Mr. MILLER. I do not mind interruption. I think this is wonderful. We learn in this way, and possibly we can give you the benefit of some of our experiences. I am one of those administrators who feel that the national legislature should have the time, as it can afford, to examine the processes of Government, and I would like to say—and it is rather in a vernacular, I think—that none of us in my Agency—and I think that is probably true of the Government generally—none of us desires to come up here and view with alarm all the time. We like to point with pride, and that I hope is what this sort of discussion will lead to.

PRESIDENT'S LONG-RANGE HEALTH PROGRAM

On November 19, 1945, and again on May 19, 1947, the President recommended to the Congress a 5-point health program as necessary to the national welfare and security. His proposals include:

1. Adequate public health services, including an expanded maternal and child-health program.
2. Additional medical research and medical education.
3. More hospitals and more doctors, in all areas of the country where they are needed.
4. Insurance against the costs of medical care.
5. Protection against loss of earnings during illness.

"We are a rich Nation and can afford many things," the President has said. "But ill health which can be prevented or cured is one thing we cannot afford." He has set our goal: "Everyone should have ready access to all necessary medical, hospital, and related services." The principal reason why people do not receive the care they need is that they cannot afford to pay for it when they need it. This is true not only of needy persons but also of a large proportion of normally self-supporting persons. Instead of segregating those who can pay for needed care from those who cannot, the President's program adopts the American formula of saving together, to meet such costs through expanding our existing compulsory social insurance system.

The two bills: The essential health needs of the Nation are of such scope and character that they can be met with reasonable adequacy only by the development of a broad and comprehensive health program. We feel that our health needs cannot be met adequately through a program of the size contemplated by S. 545, or through any program operated on a means-test basis. While I believe that a program of the dimensions proposed by S. 545 could contribute substantially toward meeting some of the most pressing health needs of the Nation, I am convinced that the bill would have to be modified in several very important respects which I have outlined more fully in my report on S. 545, which the committee has before it now, and which will be discussed at greater length by my colleagues, the Surgeon General, the Acting Commissioner for Social Security, and the Chief of the Children's Bureau.

Senator SMITH. The report to which you refer on S. 545 is the letter dated July 3, 1947, which is addressed to Hon. Robert A. Taft, chairman of this Committee on Labor and Public Welfare?

Mr. MILLER. That is correct.

Senator SMITH. That is just to identify it.

Mr. MILLER. No alternative program to the President's health program has yet been advanced which gives comparable promise of achieving, now or in the future, the goal of adequate medical care for all our people. Therefore, the Federal Security Agency endorses the basic approach of S. 1320, as it did last year with respect to S. 1606. The current bill contains a number of new or amended provisions, which in our judgment, are definite improvements. Since our testimony last year on S. 1606 stated our general position, I shall not consume your time in restating it. But I would like to call your attention to some of the major changes between S. 1320 and S. 1606, which, in my belief, make it even more desirable for enactment by the Congress as a foundation health program.

I. DECENTRALIZATION OF ADMINISTRATION

S. 1320 very clearly establishes a system of local administration, under State-wide plans. Since the Federal Government undertakes an obligation to the persons eligible under the bill, and finances the program, it reserves the right to administer the program in States where benefits would not otherwise be available. S. 1320 definitely provides for local administration within local health-service areas, by local officials or committees appointed under State plans. Many functions, placed by S. 1606 on the Surgeon General, are now placed by S. 1320 on local or State officers.

People living within the local health-service areas required to be set up by the bill are given a direct responsibility in the program's operation, through membership on local area committees and on special professional committees, which advise with the local administrative officers or committees. These committees are entrusted with substantial and important responsibilities.

Gentlemen, it has been said that S. 1320 does not really decentralize administration, since certain rule-making powers still remain by law with Federal authorities. Two observations occur to me:

1. The State health authorities who, it might be expected, would most violently react against such imputed breach of States' rights,

do not seem to find retention of Federal rule-making powers quite the bug-a-boo it appears to others. For example, at these very hearings Dr. Vlado Getting, secretary of the Association of State and Territorial Health Officers, although testifying in favor of S. 545, said:

> We believe that the Federal agency should have authority to set minimum standards in the technical aspects of the program. * * * We, therefore, recommend that the United States Public Health Service be authorized to set minimum standards as to content of program * * *.

While his remarks were directed toward a grant-in-aid proposal, they apply with even greater force to a program where the Federal Government collects the funds and establishes entitlement to benefits.

A similar view was expressed at these hearings by Dr. Reginald M. Atwater, executive secretary of the American Public Health Association, who said:

> It should be noted that S. 545 explicitly prevents Federal standards of any sort * * *. To prohibit Federal standards would set a precedent which could only result in administrative confusion and deterioration of quality of service. We believe that this provision of S. 545 is opposed to the best interests of local and State agencies and the health of the public they serve.

Still another State official expressed the same view at these hearings. Mr. Patrick Tompkins, chairman of the committee on medical care of the American Public Welfare Association, said that on the basis of their experience in administering State programs involving Federal grants-in-aid:

> * * * We are obliged to conclude that S. 545 lacks the necessary minimum provisions to protect either the taxpayer or the recipient and would place the administering State agency in an extremely difficult position * * *. The specific difficulties which we would foresee in the administration of S. 545 arises from a confusion of the roles of administrator and practitioner and an apparent fear that any standards or minimum requirements would constitute interference with the rights of the latter. The bill itself sets no standards and specifically prohibits the Federal director from doing so. This is virtually unprecedented in Federal grants-in-aid program. * * *

Apparently State authorities most intimately concerned with, and who know most about, the problem, do not share fears over retention of rule-making authority, on minimum standards, in the Federal agency. And I think no Federal administrator could very long, under the proper scrutiny of the Congress and of the people, "get away" with unduly circumscribing procedural rules. And, of course, he should not.

With all States participating in the administration of benefits under S. 1320 the role of the Federal administrative agency would be mainly to collect and allocate the funds, determine insured status of individuals, and assure that the guaranties and basic standards are complied with. Thus, responsibility for the operation of the program is decentralized to the States and to local authorities.

2. Objection to such retained rule-making power is generally voiced by supporters of S. 545. I do not believe it an ad hominem argument to point out that S. 545 also retains Federal restrictions and limitations over the States as to determination of eligibility for its benefits. Although S. 545 is espoused on the principle of States' rights, it does exactly what S. 1320 does; it sets standards of eligibility which are binding on the State. S. 545 limits the States to using the Federal funds for the needy. It is a different standard from that in S. 1320,

but it is clearly a Federal limitation on the States in the most important of all aspects of the program, the scope of coverage.

II. FEDERAL AGENCY

S. 1320 also differs from S. 1606 by providing for administration through a National Health Insurance Board of five members rather than through the Surgeon General. In a program of this scope, this is a desirable change, and is in keeping with past experience in similar programs. The relationship between this Board and the Federal Security Administrator precisely follows that which prevailed between the Social Security Board and the Federal Security Administrator, which was sanctioned by the Congress in its approval of Reorganization Plan No. 1 of 1939, creating the Federal Security Agency, and which was particularly suitable during the early development and establishment of the program.

The National Health Insurance Board, which would not be made up wholly of professional people, would be under the direction and supervision of the Federal Security Administrator, who need not be a doctor of medicine. That is completely in the American tradition. We just vanquished hard and ruthless enemies, and we did this under a system whereby the Army and Navy were under the direction and supervision of people who were civilians, some of whom in fact were required by law to be civilians.

Senator SMITH. I would like to ask there, Mr. Miller, would you make an analogy, then, between the medical profession and the Army, that the profession be run by this Board as the Army is run? Is that the point?

Mr. MILLER. I am stating historical facts here.

Senator SMITH. You refer to the Army and Navy. That is the reason I asked the question.

Mr. MILLER. Not only has it applied to the Army and Navy, but to other important Federal establishments.

Senator SMITH. Then the medical profession would be more or less drafted into the Army that would be controlled by this Board that you contemplate under social security?

Mr. MILLER. Would you repeat the question, Senator?

Senator SMITH. I say you contemplate that the medical profession will be looked upon as members of the armed forces, to be directed by this Board which you advocate?

Mr. MILLER. No; we advocate the wider flexibility, the recognition of liberalities in the partnership proposed to be set up between the Federal Government and State governments, local establishments, and the world of physicians and dentists and nurses. I certainly reject a notion of drafting the medical profession.

Senator SMITH. I assumed you would, but I wanted to bring that out to see where you draw the line, if you are setting a program of this kind for over-all coverage into the Social Security Administration.

Mr. MILLER. The analogy is in relation to what has been frequently discussed before this committee and in the Senate, and that is whether the hands of the Administrator or even of the President of the United States should be tied by the circumscription of this, that, or the other provision in setting up an establishment of such great import and proposed value to the people. For example, the provisions in the Fulbright-Taft bill formerly required that the head of the Bureau of Health had to be a physician qualified to practice in one or more of the political jurisdictions. We felt conscientiously that such requirement completely departed—aside from any notion of personal aggrandizement, of course—from the established traditions through undue restriction. So, we are attempting to point out here that much of the vital business of the Government is conducted by people who have the wide interest and understanding of the 140,000,000 American citizens in their hearts and minds and experiences and is not under the supervision of somebody whose qualifications are circumscribed by the terms of the law in education and narrowed in very important lines.

Senator SMITH. You concede, Mr. Miller, that your proposal here would be a drastic change in the present situation and asks for quite a revolutionary turn-over. You are making it part of the over-all social-security protection for the people?

Mr. MILLER. That is right.

Senator SMITH. That is your proposal?

Mr. MILLER. Yes, sir.

Senator MURRAY. My understanding, Mr. Miller, is that you do not feel that the administration of the medical-care program of the States should be under the exclusive control and direction of the medical profession merely because the subject deals with medical care?

Mr. MILLER. No. As a matter of fact, I do not want to get myself into the position here whereby, unconsciously or by lack of facility in use of the English language, I may depart from my deep respect for a profession which is so important to us from the time we come into this world till the time when we go out, but I still think that this sort of activity should be directed in or prominently supported by and concurred in by people who have a broad outlook, not only as to the value of medical service. These considerations are for Congress to determine, and I take it that what I am saying here will never be construed as truculence on my part, because I simply state our honest experiences and observations as best I can when we come before you.

Senator SMITH. Certainly you do. I am just trying to get the theory that you are approving. I take it you feel that this is a social problem rather than a health problem; that the health is secondary to the social problem?

Mr. MILLER. There isn't any one phase of American life and experience which is not involved either in the periphery or deeply centered in the business of health and medical care, and I don't believe you can operate any one of these programs without integration with the other. It has to do with welfare, public assistance, care of children, the social values involved in a contented and worth-while life, your health, medicine, education, and economic security.

Senator MURRAY. I think, Mr. Miller, we all have those sentiments that you have expressed with reference to our admiration and regard for the medical profession, but you do not feel that they should be placed in the exclusive control and management of the administration of an act dealing with medical care?

Mr. MILLER. That is true, Senator Murray.

Senator MURRAY. For instance, you would not feel that the members of the stock exchange or the security dealers of the country should be in exclusive control of the Security Exchange Commission which we have in this country to regulate the sale of securities and control the operation of stock exchanges?

Mr. MILLER. I think I would not, Senator Murray. If I may say off the record, since 1929 my interest in the New York Stock Exchange has greatly decreased. [Laughter.]

Senator MURRAY. We all had some experiences in those days, and as a result of those experiences we determined that some regulation and control should be exercised by the Federal Government.

Mr. MILLER. Senator Donnell has asked if the administrator of the Federal Security Agency was a doctor; and the honest answer had to be, of course, "no," but for just a layman I have been for 25 years pretty close to medicine, and I have learned as much about it as any layman should be trusted with. I have never had any temptation to invade the medical profession or prescribe for myself or others.

Senator MURRAY. Among the members of the medical profession, is there a feeling that they should not be placed in exclusive control and direction of any program such as we are contemplating here?

Mr. MILLER. I have no quarrel with that, but I have taken the trouble, Senator, to make an examination of the State requirements with relation to the management of their own public health activities. I find that 24 States do not require a majority on their State boards of health to be doctors; and of the 24, 12 States do not by law require even a single doctor on their State boards of health. Two States have no statutory health boards. Ten States require doctors on their State board but not in the majority.

Senator DONNELL. Mr. Miller, I take it that since 24 of the States do not require that their State boards of health be composed of a majority of doctors, it would follow that under the provisions of S. 545, which is grants-in-aid to the States, there would be no danger, in your opinion, of the medical profession monopolizing the manipulation of these funds in those 24 States?

Mr. MILLER. I yield to your conclusion, Senator.

Senator DONNELL. You agree with that statement?

Mr. MILLER. Yes. I do not fear doctors. Too many of them have taken me up into the room upstairs.

Senator DONNELL. Mr. Chairman, Mr. Miller referred a little while ago to some questioning by myself previously. I want to say about that that by silence at this point I am not assenting to all of his views, and I expect to cross-examine him a little later on, with the permission of the committee.

Senator SMITH. I think we might continue, then, with Mr. Miller's statement.

Senator PEPPER. Mr. Chairman, before Mr. Miller leaves that, I would like to ask him if what you say would paraphrase something that has been attributed to Pompey, that "war is too important a matter to be left entirely to the generals"? I think probably health is far too important a matter in the over-all picture to be left exclusively to the doctors.

Mr. MILLER. In my modest participation in one war and a half, I had to leave a good deal to the generals.

We have entrusted the most powerful force on earth, atomic energy, to a board not even one member of which is required by law to be an atomic scientist. There is no statutory requirement that our Department of Agriculture be under the direction of a farmer or that our Department of Commerce be headed by a businessman. In fact, no cabinet officer is required by statute to be a professional representative. Americans have always insisted that their major governmental establishments be headed by persons representing the public interest rather than by representatives of professional or vested interests.

Senator DONNELL. Of course, the Attorney General is an exception to that, is he not?

Mr. MILLER. I think not.

Senator DONNELL. Is he required to be a lawyer?

Mr. MILLER. I think not. I believe that at least the Solicitor General and the Assistant Attorneys General must be skilled in the law by the terms of the law itself, because much of the work before the Supreme Court, at any rate, is conducted by the Solicitor General and the Assistant Attorneys General.

Senator DONNELL. That may be. I am not familiar with the statutory provisions stating the requirements of the Attorney General, and you may be quite right. I take it, though, the custom certainly has been to choose a lawyer for Attorney General of the United States.

Mr. MILLER. I think that is obvious.

Senator DONNELL. I don't think, Mr. Miller, that you or I can recall any instance in which a person other than a lawyer has been selected as Attorney General of the United States. Is that correct?

Mr. MILLER. I think that is true. Certainly it is within your lifetime and in my longer chronological experience.

Senator DONNELL. Of course, you are much older than I am. I appreciate that.

Senator PEPPER. Before we get away from that, unless I am in error and unless the rule has been changed, there was a time when members of the supreme court of the State of the chairman did not have to be lawyers.

Senator DONNELL. That error has been cured, however, and they are required to be now.

Senator PEPPER. How long has it been since that occurred?

Senator DONNELL. About a hundred years, I think.

Senator PEPPER. Oh, no, no.

Senator SMITH. I am not certain when it was, Senator. I don't recall the history of it. In fact, I am not certain whether you are correct in your contention or not.

Senator PEPPER. Is the requirement now that they be lawyers?

Senator SMITH. The present constitutional convention is contemplating that now. Our present court of errors and appeals can have some lay members, but the majority are lawyers.

Senator MURRAY. The lay members on there are to keep the lawyer members of the court straight.

Senator SMITH. That is probably true. I am a lawyer, and I admit that lawyers might make mistakes.

Senator MURRAY. That same principle might be applied to other professions.

Senator SMITH. It might be applied to Senators, too.

Senator MURRAY. Yes; I think so.

Senator PEPPER. The people will keep watch of the Senators all right.

Senator MURRAY. It might be a good idea to have some commission sitting in the Senate to query what is going on there every day and report to the people periodically.

Senator SMITH. I think we have some voices that report to the people what is going on in the Senate. All right, Mr. Miller, will you proceed?

Mr. MILLER. It seems to me that no Cabinet officer is required by statute to be a professional representative.

It is hardly necessary to remind the members of this committee that the Surgeon General of the Public Health Service has reported for over 140 years to the Secretary of the Treasury and for the last 9 years to the Federal Security Administrator——

Senator DONNELL. It still remains true, however, Mr. Miller, that the Surgeon General of the Public Health Service himself is required to be a doctor?

Mr. MILLER. I am not sure about that.

Senator DONNELL. He is a doctor, at any rate.

Mr. MILLER. Yes.

Senator DONNELL. You cannot recall any instance in which he has not been a doctor?

Mr. MILLER. Not within my experience, Senator Donnell.

I wanted to complete the sentence—and this is not an offensive interjection, Senator—it is hardly necessary to remind the members of this committee that the Surgeon General of the Public Health Service has reported for over 140 years to the Secretary of the Treasury, and for the last 9 years to the Federal Security Administrator, neither of whom are required by law to be doctors of medicine.

It is very significant that the statutes of half of our States do not require that our State boards of health be composed of a majority of doctors, and that in a substantial proportion of these States there is not even a statutory requirement for one doctor on the State board of health (Distribution of Health Services in the Structure of Government, ch. 10; State Health Department Organizations, Public Health Reports, vol. 58, No. 14, April 2, 1943, pp. 541–577). In passing, may I note that at least five States do not by law require even their chief health officials—that is, their chief operating officials—to be doctors of medicine. I would gather from these State practices a realistic recognition that the problems of health and medical care administration involve considerations in addition to the skills required for expertness in the medical arts.

Physicians and other professional people who have criticized these similar provisions of S. 1320 seem to have forgotten that practically all of our voluntary hospitals are governed at the top by lay boards who know how to manage the institutions in the public interest while relying on their professional staffs for advice and guidance on professional matters.

This very view was adopted by one of the sponsors of S. 545, Senator Taft, in the opening day of testimony on that bill. In commenting on the relationship of S. 545 to another bill he is sponsoring, S. 140, a bill to create a Department of Health, Education, and Security, he specifically rejected the proposal that the statute require the head of the agency discharging health functions to be a doctor. He said:

> I do not think the health people should object to a health agency reporting direct to a Cabinet officer, a man of Cabinet rank, because I see no reason why such a man would not feel equally obliged to take care of health, as he does of welfare.

I agree with Senator Taft that it is not necessary to adopt arrangements which fly in the face of our whole national tradition in the Federal establishment.

III. UTILIZATION OF VOLUNTARY ORGANIZATION

In our testimony on S. 1606, last year, we discussed the role of voluntary agencies in the program. S. 1320 spells out more fully than did S. 1606 the assurances that voluntary agencies will be utilized to the fullest in the provision of services. Sections 216 and 217 guarantee broad opportunities for their participation in providing services, under circumstances which assure that they contribute to efficient and economical administration of the program.

IV. RURAL AREAS

Rural America is the most medically disadvantaged part of our country. Special attention is paid by S. 1320 to the medical and health needs of rural people. It contains many general provisions which are of special importance to rural areas. For example: (1) The establishment of local area committees, which by their nature will assure fair representation for rural people (sec. 233), and the requirement of rural representation on the State advisory committees (sec. 242 (a) (2)) and on the National Advisory Medical Policy Council (sec. 252); (2) the specific mention of consumer cooperatives in the definition of "person" (sec. 281 (e)) by whom services may be provided; (3) specific authorization in section 218 (a) (4) for the payment of mileage fees, in addition to payment for professional services, an item of great importance in rural areas; (4) clarification of the definition of "self-employed" in section 281 (a) (2), so that there will be no doubt that it includes farm operators; (5) inclusion of essential and exceptionally expensive prescription drugs in auxiliary benefits under section 201 (f), an item of considerable importance to the low-income rural population because of the current high cost of some essential drugs; and (6) flexibility in allocation of funds to States, section 272, which among other provisions would permit adequate planning for population changes due to the migration of seasonal farm labor.

In addition, you will note the inclusion of an extensive special section on rural areas, section 256, which includes important provisions designed to attract doctors to such areas, and other provisions for professional education in rural areas, for ambulance services and—in exceptional circumstances—necessary transportation of rural beneficiaries, and for special rural health information activities. This special section also requires the Board, in its annual reports, to make recommendations on measures to assure rural people equal health opportunities under the bill.

V. COVERAGE

S. 1320 follows the principle inherent in S. 1606 that, apart from beneficiaries under the old-age and survivors' insurance program and the annuitants under the Federal civil-service system, eligibility for benefits is limited to wage earners and the self-employed, and their dependents. The needy can be provided for, under sections 205 and 282, through State action in procuring voluntary coverage under the health-insurance program. While I still believe that we should not be satisfied with anything less than 100 percent coverage, I am pleased to note that S. 1320 extends eligibility to civilian Federal employees, including retired employees, and their dependents; and explicitly states the availability of eligibility to State and local government employees and their dependents, in groups, through voluntary coverage.

VI. PARTICIPATION OF PROFESSIONAL PRACTITIONERS

An important consideration in any medical-care program is its effect on the rights and prerogatives of both providers and recipients of care. On this point, I believe that S. 1320 is particularly praiseworthy. For example, I refer you to the sections relating to "Professional rights and responsibilities" (sec. 220), "Amounts of payments for services" (sec. 219), and "Local professional committees" (sec. 234), which, among others, seek to provide every possible legislative assurance that health services will be administered with democratic concern for all affected rights and interests.

Provisions in S. 1606, authorizing limitations on the number of patients a doctor may treat, were clarified in section 219 (c) of S. 1320. The committee will remember that was a provision in S. 1606. These provisions offer protection not only to the patients but even more so to the practitioners in the community against some few of their number who might abuse the system.

VII. PROTECTION OF PATIENTS

Legislative assurances are provided for patients in the program in a variety of manners: free-choice of doctors (sec. 203); nondisclosure of confidential information (sec. 254); prohibition against discrimination (sec. 255); national guaranty of benefits (sec. 202 (a)); removal of limitations on comprehensive service as rapidly as possible (sec. 202 (b)); assistance in developing personnel and other resources where deficient (secs. 202 (a), 242 (a) (5), 256, 272 (b), 273); and appeals procedures (secs. 261 and 262).

VIII. DEVELOPMENT APPROACH

While S. 1320 inaugurates a comprehensive program for making health-service benefits available throughout the Nation as rapidly and as completely as the availability of medical-care personnel and facilities will permit profiting by the hearings on S. 1606, the bill more realistically recognizes the problems posed by inequalities and inadequacies in the distribution of such facilities and personnel, and provides (sec. 202 (a) and sec. 242 (a) (5)) for surveys of the resources and needs of each State and for the development in each State of a program designed to assure maximum use of such resources as are found to be available and to overcome the inadequacies disclosed. Not only does the formula for allocation of funds among the several States in section 272 (b) require that account be taken of need for increasing the adequacy of services where the personnel and facilities are below the national average, but section 256 provides for special assistance to rural areas, and particularly those with disproportionate shortages of personnel and facilities. In addition, subsequent provision for the support of medical education in section 273 and for the liberalization and extension of the Hospital Survey and Construction Act (title III, pt. B, sec. 321) will also contribute to correction of present inequities in the distribution of the Nation's medical resources. I am much impressed by what can be done if funds are effectively channeled into medical education. Recent discussions in various parts of the country with State and other officials lead me to stress very strongly the value of vigorous financial support for medical education.

IX. PUBLIC HEALTH SERVICES

Title III complements the prepaid personal-health-services provisions of title II by provisions directed toward the development and expansion of community health services. Part A amends present statutory provisions relating to Federal grants to States for public health services (including maternal and child health and crippled children's services) so as to permit the further extension of such services and their provision on a full-time basis in every community. A substantial increase in Federal appropriations and a more effective distribution of such Federal funds to the States through a variable matching formula are among the several specific devices utilized in title III which should yield satisfying results in the form of reductions in preventable deaths and disabilities.

There are other changes between S. 1606 and S. 1320, but they are generally in the nature of details and I shall not take your time to state them.

Gentlemen, I have faith in the democratic process. These and the preceding hearings on health legislation have, in our characteristic American way, resulted in some important forward steps despite our disagreements.

S. 545 will be a start if it be amended along the lines suggested by our report. Dr. Parran will discuss this matter in more detail. I repeat, if so amended, S. 545 could contribute substantially toward meeting some of the most pressing health needs of the Nation. But the really effective way to protect our most valuable national asset, the health of our people, is through legislation of the character of S. 1320.

Senator SMITH. Are you substituting S. 545 with the changes contained in the letter of July 3, 1947, addressed to Senator Taft, referred to a few moments ago?

Mr. MILLER. Yes, sir. S. 1320 is a much improved bill over S. 1606 of the Seventy-ninth Congress. It is a bill which proceeds upon the principle that the health of each American is a concern of all Americans. It accepts the premise that a matter which so intimately affects our national security and defense is a concern of the Government of all our people, the Federal Government. It proceeds on the fundamental tenet of our national life, that in union there is strength, and it applies that principle in a characteristically American way, through insurance.

Democracy is not static. That our people are not satisfied with our present system of financing medical care is amply demonstrated by all opinion polls. We in the Federal Security Agency welcome the opportunity to work together with the Congress in devising better ways of doing what our people want done. I believe history will regard the development of universal medical care and health services of the highest American standards as inescapably part of the American scene.

Senator SMITH. I notice on the next page of your statement you say that you would like to file for the record your report on S. 545 and S. 1320.

Mr. MILLER. That does not apply now, Senator Smith, because the reports are before you.

Senator SMITH. I am very glad to have them included with your testimony here in the record, so we will visibly have your detailed conclusions on both these bills for our study in developing our legislation.

(The reports on S. 545 and S. 1320 follow:)

FEDERAL SECURITY AGENCY,
Washington, July 3, 1947.

Hon. ROBERT A. TAFT,
Chairman, Committee on Labor and Public Welfare,
United States Senate, Washington 25, D. C.

DEAR MR. CHAIRMAN: This is in reply to your letters to this Agency and the Public Health Service requesting that we submit a report on S. 545, a bill to coordinate the health functions of the Federal Government in a single agency; to amend the Public Health Service Act for the following purposes: To expand the activities of the Public Health Service; to promote and encourage medical and dental research in the National Institute of Health and through grants-in-aid to the States; to construct in the National Institute of Health a dental research institute; and for other purposes.

Title I of S. 545 would establish a National Health Agency to administer the health services of the Federal Government. Several units now in the Federal Security Agency, including the Public Health Service, the Food and Drug Administration, and the maternal and child health, and crippled children activities of the Children's Bureau, would be transferred to the new Health Agency. Seven separate offices and services in the new agency are specifically provided for, together with the functions they would perform and, in certain cases, the qualifications of their directors. Studies are to be made as to the advisability of transferring additional agencies or organizations to the National Health Agency, and as to the improvement of its internal organization.

In a series of amendments to the Public Health Service Act, title II of the bill provides for four new programs of grants-in-aid to the States in the health field. These grants-in-aid would be available on a matching basis to States submitting approved State plans (1) for making medical care inventories and surveys in each State; (2) for periodic physical examination for school children and for medical-care services for families and individuals of low incomes unable to pay the whole cost of medical and hospital services; (3) for making dental-care inventories and surveys in each State; and (4) for dental examinations for all school children, for dental care to needy school children, and, at the option of the State, for dental care to other needy persons unable to bear the entire cost of such care. At the Federal level, the medical programs wou'd be administered by the Director of the new Office of Medical and Hospital Care Services, with the assistance of a National Medical Care Advisory Council, and the dental programs would be in charge of the Director of the Office of Dental Care Services, assisted by a National Dental Health Council.

In addition, title II of the bill would authorize appropriations for cancer research and for grants-in-aid to the States for programs of cancer prevention and control. It would also establish a National Institute of Dental Research in the National Institute of Health which, in cooperation with a National Dental Health Council, would conduct, promote, and aid research into the cause, treatment, prevention, and control of dental diseases and impairments; the construction and equipment of buildings to house this new institute are also authorized.

The last title of the bill, title III, makes certain technical amendments occasioned by the reorganization of Government health agencies already mentioned, and authorizes deductions from the salaries of Federal employees, upon their request, for payments to voluntary nonprofit health-insurance funds. A special fund would be established in the Treasury to receive proceeds from taxes and other sources of revenue in amounts equal to those authorized to be appropriated by the bill, and to meet expenditures under the bill.

GENERAL DISCUSSION

It is the opinion of the Federal Security Agency that the measures proposed in S. 545 fall far short of meeting the essential health needs of the Nation. Those needs are of such scope, character, and immediacy that they can be met with reasonable adequacy only by the development under Federal auspices of a comprehensive health program such as that recommended by the President in his messages of November 19, 1945, and May 19, 1947—a program which would include measures whereby the costs of medical, dental, hospital, and nursing care can be distributed broadly by application of the insurance principle to all or most of the population, and measures for construction of needed health facilities, for expanding and improving State and local public health services, and for fostering and supporting medical education and general research in health and related fields.

We are convinced that our health needs can and should be met now on the broad front envisaged in the President's messages. We are likewise convinced that our health needs can never be met in any substantial degree of adequacy through a grant-in-aid program of the size contemplated by S. 545, or through any program operated on a "means test" basis. Experience has shown, we think, that such a test limits the availability of medical care by making people reluctant to apply for services they need until forced to do so.

If the Congress is not prepared to enact more comprehensive legislation at this time, however, we believe that a grant program of the size proposed by S. 545 could accomplish a substantial amount toward meeting some of the most pressing health needs of the Nation; but only if the bill were modified in important respects:

We believe that the Federal administrative structure proposed in title I of the bill would seriously interfere with the effective discharge of both the present health functions of the Federal Government and the new functions which would be established by the bill. Both in separating health functions from the security, education, and other related activities of the Government, and in splitting up the health functions themselves among a number of partially autonomous offices within the proposed National Health Agency, the bill would make much more difficult the coordination of Federal activities which is essential to efficient operation and would confuse and complicate Federal-State relationships in these fields. We therefore recommend the elimination of title I of the bill.

The grant-in-aid provisions of title II of the bill, by being limited to a needs-test program, appear to us to restrict the freedom of State action at the point where such restriction is the least desirable, but at the same time to omit important and desirable safeguards found in many existing grant-in-aid statutes. With financial implementation on the scale proposed the bill could not, in our judgment, even approach attainment of the objectives variously stated in section 2 (c) (to make services available "to every individual regardless of race or economic status") and in title II. Despite this obvious fact, the bill imposes a rigid structure on the States in meeting even so much of this stated goal as appears possible by requiring State health agencies to expand their programs of medical and dental care wholly on the basis of a means test, and precludes them from using these funds to strengthen and expand whatever parts of their medical- and dental-care programs they may think it most useful to enlarge. In its lack of any Federal standards relating to the quality of care to be furnished, the methods of administration, and the safeguarding of individual rights of either providers or consumers of services, on the other hand, title II seems to us to discard much that is most useful in our experience of Federal-State cooperation. We therefore recommend that title II be revised in the several respects suggested in more detail below.

TITLE I. NATIONAL HEALTH AGENCY

A. The administrative arrangements proposed in title I of the bill would, in our judgment, be a definite backward step. All of the units of Government proposed to be transferred to the National Health Agency are at present within the Federal Security Agency. The essential question of policy posed by title I of the bill, therefore, is not the consolidation within one agency of civilian health functions of the Government, which (to the extent contemplated by S. 545) is now an accomplished fact, but rather the divorcement of those functions from the educational and social security and other related functions with which they are now associated in this Agency. We do not believe that such divorcement is wise. Even the authors of the bill have apparently recognized that complete separation of health from related functions is impracticable, since they have proposed to include in the National Health Agency the entire Food and Drug Administration and to exclude the entire Office of Vocational Rehabilitation, each of which has large areas of responsibility both within and outside the field of health.

The experience of the Federal Security Agency in the 8 years of its existence has, we think, borne out the wisdom of its creation. Our reasons for this view are stated at length in our report to the Committee on Expenditures in the Executive departments, and in my testimony before that committee, on S. 140, a bill introduced by Senator Fulbright and you "To create an executive department of Government to be known as the Department of Health, Education, and Security. I will not here repeat those reasons at length, but will merely point out that the substantive program proposed in S. 545 would afford an excellent illustration of the need to continue within a single agency of the Federal Government its responsibilities in the fields of health, education, and security. Just as the creation of an independent health agency would make it practically impossible to administer effectively a school-health grant-in-aid program such as that proposed in the bill introduced in this Congress by Senators Saltonstall and Smith (the successful administration of which requires the closest coordination between health and education authorities, both Federal and State), so the separation of Federal health authorities from Federal welfare authorities proposed in S. 545 would render it extremely difficult to administer successfully a medical-care-for-the-needy program.

In terms of practical administration the truth of this seems to me self-evident. S. 545 proposes to grant funds to provide health services to people of low income, a group that would include the group already receiving or eligible to receive public assistance or general relief. The common practice among welfare authorities of considering inability to pay the costs of medical care along with other factors in determining eligibility for cash assistance or relief, and of purchasing medical services or including medical-care items in the budget on the basis of which cash payments to the needy are calculated, makes it manifest that there must be the closest correlation between cash-assistance programs and any medical-care-for-the-needy programs—correlation both in the determination of need and in the avoidance of gaps or duplications in the payments made or the services furnished. In medical and dental programs for school children, again, there would be need for close and continuing relationships with the educational authorities. The fact that these programs are for the most part operated separately in the States, far from weakening the case for a unified Federal administration, we think, makes it all the more conclusive. By its actions in plan approval, and still more in its advisory role, a single Federal agency can do much to encourage or preserve consistency among the many State plans and agencies concerned and to assure a common approach to their common problems in the fields of health, education, and security.

B. Even if the creation of a separate health agency were advisable, the internal structure of the agency proposed in S. 545 is in our opinion not well adapted to efficient administration. Not only would the bill divorce health functions from social security, education, vocational rehabilitation, and other interrelated functions, but by setting up within the new Health Agency several largely autonomous offices with functions spelled out and frozen by law, the bill would also divorce preventive from curative health services, medical services from dental services, and the compilation of statistics on health from the operating programs from which and for which the statistics are compiled. In addition, the provisions of section 108 would seem to contemplate the ultimate divorcement of research activities from all other activities in the new Agency.

Experience has amply shown that all these functions are but closely related segments of what should be a single program to meet a single problem—the betterment of the health of individuals. Their separate and independent administration within the new Agency would greatly impede efficient and economical administration, and complicate relationships between the States and the Federal Government, and between Government and the producers and consumers of health services. Yet the bill distributes the various programs among the several independent offices without giving the Administrator of the new Agency sufficient authority to effect the necessary coordination and integration of the programs, activities, policies, and procedures involved; the Administrator is not even given the usual power to supervise and direct his supposed subordinates and their activities except as he inherits it from the Federal Security Administrator with respect to the organizations now in the Federal Security Agency. Even the "general supervision" referred to in section 102 (b) (5) is vested in "the agency" rather than in the Administrator, and relates only to existing units transferred to the Agency, not to those newly created by the bill.

C. While the title of S. 545 states that one of its purposes is "to expand the activities of the Public Health Service," the bill instead proceeds to bar that Service from several important areas in the health field in which it now exercises leadership, and to give to other newly created offices in the new Agency responsibility for administering all the new programs established by the bill with the exception of the cancer- and dental-research programs.

Over a period of many years the Congress has seen fit to charge the Public Health Service with ever-increasing responsibilities in the health field, and the Service has discharged these responsibilities in a manner which we believe has earned it the full confidence of the Congress, the States, the professions concerned, and the public. It would seem to us poor policy, and not calculated to promote economical or efficient administration, to break up this going concern and replace it with a cumbersome and unwieldy superstructure, consisting of three or four new offices to deal separately with closely related activities which would duplicate in substantial part the administrative facilities which already exist.

In dismantling and subordinating the Public Health Service as proposed in S. 545, the substantial progress which has been made in developing a Federal health program through the coordination of the several elements in this program in one Federal health organization—the Public Health Service—would be lost. Traditional relationships built up over the years between the States and the Public Health Service—relationships of which this Agency is proud and which have been commended repeatedly by the States—would be jeopardized. The vast and varied experience of the Public Health Service in the administration of health services would be wasted, or utilized to only a very limited degree in organizing and administering the new programs. The steady progress toward simplified and economical administration of health programs, to which the Public Health Service has contributed so substantially, would be stopped.

D. The provision for study of the desirability of retaining or modifying the Commissioned Corps of the Public Health Service is appropriate. As the bill recognizes, such a study should approach the problem from the viewpoint of the entire organization of which the Commissioned Corps is a part, and should be directed toward means for attracting and retaining in the Federal Service well trained and competent physicians, dentists, and other professional personnel. An undertaking of such scope, however, would require considerably more time than the 6 months' period stipulated in the bill, probably 2 years or more.

E. Section 103 (b) would transfer to the proposed National Health Agency the Division of Health Studies (sic) in the Bureau of Research and Statistics of the Social Security Administration. That Bureau contains a Division of Health and Disability Studies, concerned wholly with social-security problems and in large part with disability insurance. These are necessary research equipment for the Social Security Administration. It should not be deprived of them by any disposal to establish a separate health agency.

F. The bill would also transfer the maternal and child health and crippled children's services from the Children's Bureau. The close relation of these health services to the welfare programs administered by the Children's Bureau affords another illustration of the necessity that all such interrelated functions be kept under a single room. The advantages of having the health and welfare services for children in the same Bureau are great. It not only facilitates coordinated administrative planning in the interest of children in these closely related fields, but also serves as a basis for more realistic and integrated planning in relation to other services needed by children provided elsewhere.

TITLE II. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

A. The provision for the establishment of cancer-control program, substantially along the lines of the venereal disease and tuberculosis programs, is under present circumstances sound and desirable. This section, however, should be clarified or broadened to make certain that aid for treatment as well as for research, diagnosis, and case finding would be authorized; determination of the presence of cancer would be of doubtful value without assurance of treatment. Similarly, the ceiling on the amount of funds should be raised or eliminated to enable the carrying on of an adequate cancer-control program.

B. The proposed new title VII of the Public Health Service Act, to be entitled "General Medical Service for Families and Individuals with Low Incomes," cannot be considered a suitable substitute for a comprehensive medical- and hospital-care program based on the principles of social insurance. A program of the size and kind proposed in S. 545 would inevitably fall far short of accomplishing even the lesser and very different objective (as stated in sec. 711 and 712 of the bill) of making available medical and hospital services to all those whose economic status is such as to render them unable to pay the full cost of such services. Except in the case of a few of the more wealthy States, the sums made available by S. 545, together with sums contributed by States and their governmental subdivisions, would probably do no more than enable the States during the 5 years of Federal grants to make adequate provision for the medical and hospital care of those individuals whose income is so low as to render them eligible for public assistance or other Government relief.

We believe that it would be preferable to leave a wider latitude to the States in utilizing for medical care such Federal funds as the bill would make available for that purpose. Instead of using these funds exclusively for services to persons of low income, some States might reasonably conclude that they could better advance their over-all health objectives by applying some portion of this new money to the expansion or improvement of existing programs, or the establishment of new ones, not bounded wholly in economic terms—programs for the chronically ill, for example; programs for persons suffering from particular diseases, such as tuberculosis, cancer, or heart disease, which have a high morbidity or mortality incidence, or which require extensive care or specialized therapy, or programs for the development of diagnostic or other specialized services. As you know, many such programs have traditionally been operated without a means test, and we think the Federal Government should not discourage their continuance or expansion on the traditional basis.

There is much evidence that when there are two systems of medical care, one for the poor and the other for those who can afford to make payment out of their own resources, it is very difficult if not impossible to avoid having different standards of care. This is not to say that physicians as a whole have different attitudes toward people on the basis of their economic status. A doctor who is motivated solely by the best interests of his patient may hesitate to ask for an X-ray if his patient is financially pressed, even though the X-ray may make the difference between accurate diagnosis and empirical judgment.

Finally, it is surprising that nowhere in the bill is there any provisions for coordination between health, welfare, and education authorities or programs of the States. It should also be pointed out that the provisions for "collection of proper charges of less than the total cost of such services" rendered to individuals and families "unable to pay in whole, but able to pay in part therefor" would require the States to set up complicated and costly overhead administration. Unless a simple affirmation of income were to be accepted, the investigation of family finances entailed, and indeed the entire means-test philosophy, would be administratively unwieldly to an extreme degree.

We believe that this bill, with the objectives of its medical, hospital, and dental care programs modified, and with the methods for attaining these objectives correspondingly changed and improved, in the respects noted below, could accomplish much by way of meeting some of our most pressing health needs:

1. *State initiative and determination.*—In its provision that the Federal funds may be used only for medical care of families and individuals of "low income," the bill departs from what otherwise appears to be one of its basic principles—that of affording maximum opportunity for State initiative and determination. S. 545 very soundly requires that each State plan must be based on a survey of existing medical and hospital services within the State and that the plan must be fashinoed to meet first needs first. The stipulation that Federal funds can be used only to provide care for persons and individuals of low income, however, would deter States from establishing programs designed to meet their particular health needs as disclosed by the survey. In addition, State plans should be permitted to provide for such widespread problems as adequate care of children and mothers during maternity and of the chronic sick, improved quality of medical care through availability of diagnostic facilities, and more widespread use of hospital facilities, particularly for acute illness. These problems affect all groups within the population and are not confined to persons with low income. In requiring the States to impose a means test, the bill is far more restrictive upon the States than are existing Federal laws in the health field and than are health bills now pending in Congress such as S. 678 (as its sponsor, Senator Lodge, has proposed to amend it) or S. 1290 introduced by Senators Saltonstall and Smith.

It is our view that whatever sums the Congress may determine to authorize for this purpose in a general grant-in-aid medical-care program should be available to meet such part of the existing need for medical care in each State as that State may think the most urgent, and that there should be no Federal restriction to persons of low income.

2. *Plan conditions.*—In general, the conditions imposed on State plans are not such as to assure reasonably adequate and well coordinated medical care to those that would be aided under the bill. The bill fails to provide the minimum standards and safeguards—Federal, State, and local—necessary to assure that the Federal funds are used efficiently and effectively for the intended purposes, that services are adequate and comprehensive, and that the rights of the public, the professions, and the hospitals are safeguarded. In the light of our experience in administering Federal grants to the States in the health and welfare fields, the omission of such standards and safeguards must be regarded as a serious impediment to the success of the health programs provided for and to the maintenance of a balanced Federal-State partnership and responsibility of effort. At the minimum the bill should include prohibitions against excessive residence or citizenship requirements, prohibitions against discrimination for race, creed, or color, assurances that the non-Federal share includes State funds, assurances that eligibility determinations will be made by responsible Government officials and not left to persons or agencies which the Government cannot hold responsible for carrying out a declared public policy, assurances that fair hearings will be provided and that information will be regarded as confidential, and requirements for efficient administration including a merit system for administrative employees. Finally, in order to safeguard the quality of services to be given—particularly when such services are to be made available only to those persons who are not able to pay for care from their own resources—it is necessary that the State agency be required to establish State standards governing the kind of care which is to be made available as part of the State plan, and be responsible for their being observed throughout the State.

3. *Voluntary agencies.*—Furthermore, there is no provision for the establishment of standards governing arrangements with voluntary health plans through which the States would be permitted to provide services. The policy of entrusting to nongovernmental organizations the administration, at public expense, of health services to large groups of the population, seems to us unsound.

It is difficult enough at best to assure that services secured in this fashion will be of high quality and will be obtained at reasonable cost. The vulnerability of such a system to abuses renders it especially important, if the Congress determines to make Federal funds available for the purpose, that it should do so only when a State agency has proposed administrative techniques calculated to minimize these dangers.

The bill might be construed not to permit use of Federal funds to buy services from a compulsory health insurance system. Should any State establish such a system, it seems to us manifest that the funds granted under S. 545 should be available for the purchase of services from the insurance system, at least for needy persons not otherwise entitled to the benefits of that system, and preferably for any other groups which the State might select.

4. *Scope of services.*—Provision of comprehensive medical care would not be assured even to persons covered under the program, since the States are given the option to restrict the services which they provide to institutional care, home care, and/or office care. For example, how may the mandatory provision for hospital care be met if the State elects to provide services only in the physicians' offices? In leaving the provision of home, office, and institutional services to the needy entirely optional with the State, the bill may well reverse the growing trend toward continuity of medical services in all stages.

5. *Allotment and matching.*—The allotment and matching provisions, taken together, are seriously faulty. At best, they are likely to require that the wealthiest States would have to put up the smallest proportions of their aggregate incomes in order to receive the allotments of Federal funds and that the poorest States would have to put up the largest proportions. At worst, since it would appear that States could use present expenditures to match the Federal allotments, the proposals could operate so that the wealthiest States could qualify for their allotments with little or no new expenditures, while the poorest States might have to increase their present expenditures. In this connection it should be noted that at least a considerable part of State and local expenditures for community-wide preventive or other health services could apparently not be counted for matching purposes.

While the allotment formula takes account of the varying financial capacity of the several States, the purpose of equalization would be far better served if instead of a uniform 1:1 matching ratio a variable matching ratio should be used, so that proportionately less financial participation would be required from the poorer than from the more prosperous States.

It may nevertheless be anticipated that the total outlay for medical and hospital care would be increased mainly by the amounts of the Federal grants-in-aid. Under these circumstances it is very likely that there would be little, if any, redistribution of existing personnel and facilities to conform better to the needs of the population.

6. *Authorized ceiling.*—As we have already pointed out, the funds authorized to be appropriated, even if matched by as much State money, would be sufficient to assist only a small fraction of the population requiring assistance to meet the costs of medical, hospital, and related services. In 1939, in the course of the Senate hearings on S. 1620, the American Medical Association stated, in connection with its testimony, that persons with a family income of less than $1,500 require assistance to pay medical bills for minor or for major illness; that persons in families with incomes of $1,500 to $3,000 would require assistance for medical care when confronted with major illness. In 1939, about 90 percent of our population were in families with incomes of less than $3,000 per annum. Allowing for price changes as well as for increased income, it would not be unreasonable to assume that at least 70 to 75 percent of our population will need assistance when confronted with serious illness. A succession of minor illnesses, moreover, or a single major illness, may deplete the resources of families who are relatively well off. A chronic illness may wipe out the savings of years. While in any given year, only a small percentage of the population may have large medical costs, in a generation the great majority of families will have been affected. Yet under S. 545 persons who do not fall within the definition of low income would be denied care until their resources are depleted. This seems poor economy in terms of public planning.

Even though it may be true that in any given year only 20 or 25 percent of the population may require aid under such a program as is proposed in S. 545 the medical bills incurred by this particular 20 or 25 percent would account annually for 50 to 60 percent, or more, of the total national expenditures for medical care. To fulfill the stated objectives of the bill, the amounts would have to be raised to many times the $200,000,000 authorized in the bill, as this amount would not go much beyond providing adequate medical care to those in receipt of public aid.

7. *Advisory Councils.*—To assure democratic operation of the program at the local level, provision should be made for local participation as through advisory councils, and representatives of the public should be required as members of such councils, both State and local.

8. *National Council.*—Finally, we believe it is unwise to confer upon a part-time council such administrative functions as are proposed in this title for the National Medical Care Council. Also, the provision relating to the composition of this council is so worded that it would be possible for all members to be individuals with a professional interest in health and medical care. It is important to clarify that representatives of the users of the services and of the

general public interest must be included on all councils advising on health and medical care. Since technical committees can be utilized for professional advice, and since this council will be concerned primarily with public policy, it would seem that at least a majority of the members of the council should be representatives primarily of the public interest.

C. Most of the above criticisms are applicable to the proposed title VIII of the Public Health Service Act, "Dental health services for school children and families and individuals with low income." The amounts of money authorized in relation to the size of the problem are particularly inadequate. In addition, this amendment appears undesirable because provision for the periodic inspection of the teeth of all children enrolled in the elementary and secondary grades of the public and private schools, with stringent limitations on eligibility for preventive or reparative service, would constitute a serious waste of dental manpower. Since almost all children are afflicted with dental disease, the periodic examination of children merely to find the same dental defects and diseases year after year is not justifiable. For the vast majority of our children, it is not a question of parents being unwilling to carry out the recommendations which are made, but much more of their economic difficulty in doing so. In 1941 three out of five of the children in this country were living in families with incomes less than $2,100 per year, and four out of five in families with annual incomes of less than $3,000. Moreover, 80 percent of children live in families of four or more persons.

Again, on the theory of giving maximum leeway to the States, the performance of orthodontia should not be ruled out by Federal statute.

The National Dental Health Council has too great a weighting of dentists. At the most, the legislation should require that three (instead of four) of the six members of the council be doctors of dental surgery.

D. Amendments to the Public Health Service Act that would add "Title IX—Further research and training, part A—dental research," for the establishment of a National Institute of Dental Research, are sound in principle; though the proposed section 902 of the Public Health Service Act would be redundant, in view of the broad authority already contained in section 301. However, the funds authorized for grants-in-aid for dental research and training and for research and scholarships within the institute (ranging up to $300,000 annually for each purpose for fiscal year 1949 and thereafter) are too small for the important purposes to be accomplished. No legislative limit has hitherto been placed upon the funds which may be appropriated for research within the National Institute of Health, and it is suggested that this provision of the bill should authorize whatever appropriations may be necessary.

The problems of research with which the National Institute of Dental Research will be occupied are sufficiently different from those relating to provision of dental services to children and others as to suggest the desirability of a separate dental advisory council to be established in connection with the institute.

TITLE III. MISCELLANEOUS

The major substantive provision of this title, and the only one on which we shall comment, would be authorization for the deduction from the salaries of Government employees, upon their request, of payments to any public or private nonprofit health insurance fund. In principle we favor such a provision, but we see several serious objections to section 306 of the bill in its present form. In the first place, the section contains no authorization to set or to enforce standards to assure either that the services will be of good quality or that the charges will be reasonably related to the service offered; yet governmental assistance in the collection of premiums would involve governmental expenditure to perform this function and would be bound to imply to many persons governmental indorsement of the organizations to which the payments are made. The term "voluntary nonprofit health insurance fund," moreover, is so broadly defined as to embrace many organizations and purposes that would hardly fall within the ordinary concept of "health insurance." Finally, with no limitations upon the number of such organizations for which deductions might be required and no uniformity in the sums or percentages to be deducted, with complete freedom to each officer or employee to choose whatever organization or organizations he likes and to change his choice whenever he wishes, the administrative burden upon the several Government agencies would appear to be excessive. If a provision could be drawn which would meet these objections, we should be in favor of its enactment.

We shall make no comment on section 307, which would direct that certain tax proceeds be set aside to finance expenditures under the bill. This section raises questions which appear to concern the Treasury Department and the Bureau of the Budget more than this Agency.

Sincerely yours,

WATSON B. MILLER, *Administrator.*

FEDERAL SECURITY AGENCY,
Washington, July 3, 1947.

Hon. ROBERT A. TAFT,
Chairman, Committee on Labor and Public Welfare,
United States Senate, Washington 25, D. C.

DEAR MR. CHAIRMAN: This is in response to your letter of May 25, 1947, requesting that we submit a report on S. 1320, a bill "To provide a national health insurance and public health program."

The provisions of S. 1320 are made under three titles.

Title I contains a statement of findings and declarations relating to the essentiality of good health to the security and progress of the Nation and the inadequacies in the present availability of health services to the people.

Title II outlines and establishes a Nation-wide program of prepaid personal health service benefits to be administered through State and local authorities in accordance with Federal standards. In addition, provisions are made for grants-in-aid for medical research and education. The provisions of this title are similar in scope and objectives to those of the health insurance provisions contained in S. 1606, extensive hearings on which were held during the Seventy-ninth Congress, but a number of significant changes have been incorporated in the current bill. Some of these changes will be identified and discussed later in this report.

Title III augments the prepaid personal health services provisions of title II by provisions directed toward the development and expansion of public health services. Part A of this title amends present statutory provisions relating to Federal grants to States for public health services (including maternal and child health and crippled children's services) so as to permit the further extension of such services and their provision on a full-time basis in every community. Part B contains amendments to the Hospital Survey and Construction Act designed to increase the total authorized Federal appropriations for the construction of hospital facilities and to liberalize the matching ratio between Federal and State funds.

TITLE I. DECLARATION OF PURPOSE

Entirely apart from the specific provisions contained in titles II and III, the statement of policy in title I is of major importance. If this title should be enacted into law it would represent a landmark in legislative recognition of the obligation of the Federal Government, in cooperation with the States and their subdivisions, to take all necessary and feasible steps toward the achievement of the goal of a healthy Nation. It would reject all artificial distinctions between public health and individual health. Such a statement of policy would provide the only foundation upon which a completely adequate national health program can be inaugurated.

TITLE II. PREPAID PERSONAL HEALTH SERVICE BENEFITS

In our testimony on S. 1606 (79th Cong.) we called attention to the present inadequacies in the medical care received by or available to large percentages of our people and expressed our conviction that a Nation-wide health insurance program designed to provide comprehensive health services to all, or virtually all, of our people appeared to be the most effective means of overcoming our present inadequacies. We therefore endorsed the basic approach of S. 1606, although a number of specific amendments or modifications were recommended. Nothing has happened in the past year to alter this basic position. The need for more medical care more equitably distributed is still acute. The economic barrier between doctors and patients is still widespread. And no alternative program has yet been advanced which gives comparable promise of achieving—now or in the future—the goal of adequate medical care for all our people. The Federal Security Agency has therefore only to reiterate its general endorsement of the basic features common to S. 1320 and its predecessor, S. 1606 (79th Cong.). In addition, however, the current bill (S. 1320) contains a number of new or amended provisions which, in our judgment, make it a much more desirable bill than its predecessor. It is to these new or modified provisions that the following comments are directed.

1. S. 1320 inaugurates a comprehensive program for making health service benefits available throughout the Nation as rapidly and as completely as the availability of medical care personnel and facilities will permit. Profiting by the hearings on S. 1606, the bill more realistically recognizes the problems posed by inequalities and inadequacies in the distribution of such facilities and personnel, and provides (section 202 (a)) and section 242 (a) (5)) for surveys of the resources and needs of each State and for the development in each State of a program designed to assure maximum use of such resources as are found to be available and to overcome the inadequacies disclosed. Not only does the formula for allocation of funds among the several States in section 272 (b) require that account be taken of need for increasing the adequacy of services where the personnel and facilities are below the national average, but section 256 makes special provision for rural areas, and particularly those with disproportionate shortages of personnel and facilities. In addition, subsequent provisions for the support of medical education in section 273 and for the liberalization and extension of the Hospital Construction Act (title III, part B, section 321) will measurably contribute to an early correction of present inequities in the distribution of the Nation's medical resources.

2. Perhaps the most prominent revisions incorporated in S. 1320, as compared with its predecessor, are those relating to the allocation of administrative responsibilities. We heartily support the bill's plan to carry out its benefit provisions through State administration, With all States participating in the administration of benefits, the role of the Federal administrative agencies would be mainly to collect and allocate the funds, determine insured status of individuals and assure that the guarantees and basic standards are complied with. Thus, responsibility for the operation of the program is decentralized to the States and to local authorities.

3. In view of the emphasis which has so often been given to the need for flexibility and experimentation in the development of health program of national scope. it is gratifying to note the wide area of administrative discretion that is assured to State and local authorities in the administration of the program. This flexibility, together with such provisions as those relating to studies and reports (sections 253. 256 (b), etc.) and to State-wide meetings of local administrative personnel, offer assurance that the administrative pattern will not be static but will be adjusted and improved in each State in the light of actual administrative experience.

4. S. 1320 clarifies the role of voluntary agencies in the provision of services under the proposed program (sections 216 and 217). These provisions offer broad opportunities for participation by such voluntary agencies in providing services. while at the same time they vest in Federal and State administrative agencies the necessary responsibility and authority for assuring that voluntary agencies must conform to prescribed standards, so as to assure that their participation will contribute to efficient and economical administration of the program. Such assurance is a necessary and desirable safeguard, since experience in other countries provides a warning that an administrative structure which is complex and diffused in its distribution of responsibility may undermine the effectiveness of the entire program.

5. The bill is also commendable for its recognition of the need for close coordination and interlocking of preventive, diagnostic, and therapeutic health programs. At the State and local level, as well as in the provisions relating to Federal administration, the bill repeatedly encourages administration of all health programs under the direction or supervision of a single agency. This approach meets with our wholehearted approval. It would be a serious and costly error indeed if, in attempting to provide for one of the essential elements of a comprehensive national-health program, we should undermine the very unity and comprehensiveness of the program which we are seeking to establish.

6. S. 1320 differs from S. 1606 by providing for a National Health Insurance Board instead of the Surgeon General of the Public Health Service as the Federal administrative agency. ' We recognize and sympathize with the desire of the sponsors of this bill to dispel any public apprehension lest a single administrator be tempted to abuse his authority in a field in which so many interests are at stake. This is certainly a proper concern, particularly during the initial stages of a national health-insurance program.

We do have some reservations with regard to the provisions of the bill (section 232) permitting administrative authority to be vested in local administrative committees, but here the optional form of local organization permits a degree of local discretion which is consistent with the general policy of decentralized administration provided by the bill.

7. An important consideration in any medical-care program is its effect on the rights and prerogatives of both providers and recipients of care. On this point, we believe that the revised bill is particularly praiseworthy. In the sections relating to Professional Rights and Responsibilities (sec. 220; see also secs. 219 and 234), Non-Disclosure of Information (sec. 254), Prohibition Against Discrimination (sec. 255), and Complaints of Eligible Individuals and of Persons Furnishing Benefits (sec. 262), every possible legislative assurance has been given that health services will be administered with democratic concern for all affected rights and interests.

8. With respect to the eligibility provisions of S. 1320, it is gratifying to note that the bill now includes protection for Federal employees, who were not covered under the predecessor bill. While we still believe that we should not be satisfied with anything less than 100-percent coverage, we recognize the reasons which led to the coverage limitations in this bill. Since persons who are financially needy constitute a group most in need of coverage, we are in accord with the provisions of sections 205 and 282, which authorize a State to use its public assistance grants under titles I, IV, and X of the Social Security Act for payments of premiums into the personal-health-services account on behalf of needy persons.

9. Brief reference was made earlier in this report to the provision in S. 1320 (sec. 273) with respect to grants for medical research and education. In concluding our comments on title II, however, we should like to reiterate and reemphasize our endorsement of this provision, which we consider to be of outstanding importance. We should particularly like to emphasize the need for grants to assist in the training of medical personnel. While other legislation enacted by Congress, or now under consideration, has focused public attention on the need for medical research, no direct attack upon our acute shortage of medical personnel has yet been authorized by Congress. Even if a comprehensive medical-care program, such as provided by S. 1320, is not adopted by the Congress, we are faced with current personnel shortages. But if title II of S. 1320 should become law, these shortages would become even more urgent, for the distinction between need for medical care, on the one hand, and effective economic demand, on the other hand, would be virtually obliterated. In fact, one of the fundamental objectives of S. 1320 is to equate medical services with medical care needs. This cannot be achieved with the personnel we now have. The provisions of section 273 of S. 1320 would go a long way toward the ultimate provision of adequate medical and related personnel for the Nation. If it is assumed that half of the funds authorized by this section (beginning with the third year, 2 percent of the amount expended for benefits) would be allocated to grants for education, this would yield a sum, roughly, as large as the total present budgets for the Nation's medical and dental schools. This is a large figure, but it is large primarily because it represents a realistic measure of the inadequacies in our current "production rate" for medical and other health personnel.

Section 273 states the objectives, which are of the first importance, and provides the financial means for their attainment. In considering the section for enactment the Congress will probably wish to consider the development of provisions prescribing the methods or criteria to be used in distributing the funds, the methods of administration, and other aspects of this important program; but because of its intimate relationship to other programs of research and education which are still in the formative stage, we are not prepared at this time to submit recommendations for the more specific development of section 273.

TITLE III. DEVELOPMENT AND EXPANSION OF HEALTH SERVICES

Part A. Grants to States for health services

S. 1320 advisedly does not concentrate on the provision of individual health services at the expense of the community health programs which have up to the present comprised the principal concern of public-health authorities. While the record of progress in this field over the past four or five decades has been one of remarkable achievement, we cannot afford to be complacent. Roughly a third of our counties are still without full-time public-health services, and the effectiveness of programs in all communities could be still further extended and improved with the definite assurance that such progress would yield satisfying results in the form of reductions in preventable deaths and disabiilties.

Part A of title III recognizes the need for strengthening community health services and provides several specific means for achieving this objective. First, section 301 provides a broad and flexible statement of the purpose and availability of Federal grants and thereby provides an adequate basis for a comprehensive and progressive community program. Second, section 302 authorizes a progressive and substantial increase in Federal appropriations for financial support to States and local public-health programs. Third, the bill provides (secs. 305, 306, and 307) for more effective distribution of Federal aid by establishing a definite objective grant formula on a varying matching basis, so that the less prosperous States would receive the greatest proportionate amount of financial assistance. Fourth, this title sets a definite goal of a Nation-wide coverage by specifying, in paragraph (4) of sec. 304 (a), that State plans must assure the coverage of every community in the State with an adequate public-health organization within 10 years of approval of the first plan.

Finally, title III contemplates, at the option of each State, a single grant to the State covering all public-health services, as opposed to the separate earmarked grants required under present laws. The committee and the Congress will, no doubt, want to give careful consideration to this approach, with its possible contribution to simplified administration and balanced programs, as well as to the traditional alternative approach of providing or earmarking separate grants for special programs.

Part B. Construction of health facilities

Part B of title III consists of a series of proposed amendments to the Hospital Survey and Construction Act of 1946, all of which meet with my complete approval. Section 321 increases the authorized annual appropriations provided in the original act and extends the life of the program from 5 to 10 years. Over the 10-year period, the Federal appropriations authorized by this section would total $975,000,000, which, together with the State matching funds, provides a much more realistic fiscal estimate of the unmet hospital and health center needs of the Nation than that authorized in the present act. In addition to increasing the total amount of Federal funds available, this bill would enhance the effectiveness of the hospital construction program in correcting the present inequitable geographic distribution of hospital facilities by two other modifications of the original act. First, it would provide for State-by-State variation in the Federal contribution to the cost of construction projects as opposed to the present uniform matching requirements. This would be a distinct improvement, since it is somewhat inconsistent to make larger gross allotments to poorer States without allowing for any variation in the matching requirements for individual hospital construction projects. Second, it is proposed to amend the present act so as to eliminate the requirement that a local applicant must demonstrate ability to meet maintenance and operation costs as a prerequisite to a construction grant. Under a system of Nation-wide prepaid medical and hospital benefits, such as that outlined in title II of S. 1320, the problem of meeting maintenance costs for hospitals in low-income areas would, of course, be greatly simplified, and this amendment to the Hospital Survey and Construction Act would be a logical one.

In the light of these comments, we would, therefore, recommend that this bill be enacted by the Congress.

Sincerely yours,

WATSON B. MILLER, *Administrator.*

Senator DONNELL. Mr. Miller, as you have indicated, you are the Federal Security Administrator. How long have you occupied that position?

Mr. MILLER. Since the 12th of October 1945, Senator.

Senator DONNELL. I would like to ask just a little about your biographical data, Mr. Miller, if I may.

In the first place, where were you born?

Mr. MILLER. The Senator will find it not very important, but it is something I am very glad to give to you.

Senator DONNELL. I think it has a bearing, in view of certain provisions in the bill, and I shall point those provisions out later, and I trust the witness will not object at all to the inquiries that I shall make. I do not think any of them will be improper at all.

Will you tell us, Mr. Miller, where you were born?

Mr. MILLER. In Indiana.

Senator DONNELL. And when were you born?

Mr. MILLER. On April 1, 1879.

Senator DONNELL. You were educated where?

Senator PEPPER. Day of the week—we might get the day of the week.

Senator DONNELL. Just a minute—I suggest for the record that this is a serious examination and is being conducted in that way.

Senator PEPPER. That is merely a suggestion. I wanted to know whether it was in the full of the moon or what. It might be important.

Senator DONNELL. I observe the serious nature of the Senator's questions, and they are, of course, noted in the record.

Now, Mr. Miller, will you be kind enough to tell us where you received your preliminary education?

Mr. MILLER. In the public schools of the State of Illinois.

Senator DONNELL. And were you graduated there and from one of the high schools in Illinois?

Mr. MILLER. I was not.

Senator DONNELL. How far did you proceed in your work in school?

Mr. MILLER. To the seventh grade.

Senator DONNELL. Then what further educational work did you pursue in any educational institution?

Mr. MILLER. None in a school.

Senator DONNELL. When did you finish your work in the seventh grade in the Illinois schools?

Mr. MILLER. I think at the age of 16, Senator.

Senator DONNELL. That would be in 1895?

Mr. MILLER. About that.

Senator DONNELL. And what did you do then, say, for the next 10 years?

Mr. MILLER. I had to go to work to support a rather large family of younger brothers because of a long-continued chronic illness of my father, who was the breadwinner.

Senator DONNELL. And what line of work did you follow?

Mr. MILLER. I swept out drygoods stores, washed windows, carried papers, milked cows, drove cattle and sheep. I did take some courses in the International Correspondence School, of Scranton, Pa.

Senator DONNELL. And what was your first major job that you had after you left school?

Mr. MILLER. Well, those activities that I have just mentioned were affairs requiring my full time and some evening time and for the purpose of scratching up a little money to buy food.

Senator DONNELL. Well, Mr. Miller, there is no intimation of any lack of respect for those activities. They are honorable and proper, and I honor you for them, but what I am trying to get at is your experience.

Mr. MILLER. It almost broke my parents' hearts. I remember that.

Senator DONNELL. I don't mean any reflection in the slightest, directly or indirectly or inferentially. I am simply asking about your experience.

What I wanted to find out is as to the work you have detailed—what was your first employment along your ultimate line of employment.

Mr. MILLER. Full-time job?

Senator DONNELL. Yes.

Mr. MILLER. I think perhaps the first thing is not important. My father was an engineer; and, partially recovering his health, he came to Washington and went to work for the General Land Office in a quasi engineering capacity. He had a good deal of field work in the Rocky Mountains; and as he could, at times, as my brothers came out of high school, he took us out on field work, and I learned to couple with my studies in mathematics and arithmetic and plane and spherical trigonometry—I learned the rudiments of engineering and was paid for it.

At one time I was employed for several years, while the boys were going through school, in a large Washington mercantile establishment as a salesman.

Senator DONNELL. Shall we count that as, in your opinion, the first full-time job, or had you had some other full-time job prior to that? I don't want to go into the greatest details.

Mr. MILLER. My earliest job in a Bloomington, Ill., department store was a full-time job.

Senator DONNELL. Then you came on to Washington, as you have detailed, and you were employed here in one of the large mercantile establishments in Washington?

Mr. MILLER. That is right.

Senator DONNELL. By the time you were 21, where were you located?

Mr. MILLER. I was located in the mercantile establishment in Washington.

Senator DONNELL. How long did you continue in that line of work?

Mr. MILLER. From the age of about 21 to 28, as I best remember, Senator Donnell, and at that time I helped to organize a brick-manufacturing concern in Baltimore, to which I gave my full time.

Senator DONNELL. For how long were you with the brick-manufacturing company, at the age of 28, which I understand was in 1903?

Mr. MILLER. There is something wrong with my chronology there. It is difficult for me to get those dates established with accuracy at this moment.

Senator DONNELL. Just approximately, how long were you with the brick company and in about what year?

Mr. MILLER. Well, in 1908 I spent 4 or 5 years in Baltimore in the brick-manufacturing business, and then the next definite date that I can remember is that I helped organize a small business contracting establishment here in Washington. I remember that date because of the——

Senator DONNELL. What was the date?

Mr. MILLER. 1921, the year in which the corporation was effectuated.

Senator DONNELL. What type of contracting was that?

Mr. MILLER. Designing and manufacturing of bank equipment, permanent fixtures for banks, and some fixtures to go in public buildings, such as State capitol buildings, and that involved allegorical paintings and massive bronze decorative things. Among other things we helped to design and manufacture all of the furniture in the New House Office Building.

Senator **Donnell**. For how long a period, approximately, after 1921 did you continue in that line of work?

Mr. **Miller**. The war came along, and I enlisted, and that was about 1917. I continued my ownership of minority stock until the business was dissolved by the death of the other principal incorporator in 1943, but for many years I had no time to pay any attention to the business, and for 5 or 6 years I was not even in the office.

Senator **Pepper**. Let him state his war experience.

Senator **Donnell**. Yes; I will be glad to have you state your service in the war. That is the First World War?

Mr. **Miller**. That is right.

Senator **Donnell**. Will you state your service?

Mr. **Miller**. I was commissioned a first lieutenant in the Motor Transport Corps, which was a staff corps organized for the purpose of that war, which does not now exist, I believe, and for the most part I trained troops in Camp Johnson, Fla., and Camp Sheridan, Ala., near Montgomery, and commanded motor transport of all descriptions and collected the overseas material. I was in Hoboken, N. J., ready to embark when the armistice was signed.

Senator **Donnell**. Then have you finished now the military work?

Mr. **Miller**. Yes.

Senator **Donnell**. Then, after your war experience, did you then return here in this contracting work, or had it yet been started?

Mr. **Miller**. Just before I went into the service there was a little of that work done under kind of a partnership between a gentleman who is now dead and myself, but the corporation was after I returned from the service in 1921. I returned from the service, however, in 1919.

Senator **Donnell**. But the company was incorporated in 1921?

Mr. **Miller**. That is right. And I was also owner of one-third of a bus transportation company.

Senator **Donnell**. For how many years, approximately, did you continue active in that company, devoting substantially all of your time to it?

Mr. **Miller**. Just about until December 1923.

Senator **Donnell**. Was it 1923, about two years?

Mr. **Miller**. Full time; yes, sir.

Senator **Donnell**. From that time on, say for the next 10 years, what did you then do?

Mr. **Miller**. In December of 1923 I was appointed chairman of the national rehabilitation committee of the American Legion, which, of course, has to do with the things we are talking about now.

Senator **Donnell**. That was 1923?

Mr. **Miller**. Yes, sir.

Senator **Donnell**. How long did you serve in that capacity?

Mr. **Miller**. Eighteen years.

Senator **Donnell**. That brings us up to 1941?

Mr. **Miller**. Yes, sir.

Senator DONNELL. Did you devote practically all your time to the American Legion work in that period?

Mr. MILLER. All of it practically. I did visit and conferred in the offices of the corporation, however.

Senator DONNELL. Then in 1941 did you discontinue that work?

Mr. MILLER. I was called by the Government to enter the Federal Security Agency.

Senator DONNELL. That was in 1941? In what capacity?

Mr. MILLER. Assistant Administrator.

Senator DONNELL. Did you succeed Mr. McNutt in that capacity, or was it in some other capacity you succeeded him?

Mr. MILLER. I succeeded Mr. McNutt in October 1945, as Administrator.

Senator DONNELL. So from 1941 until 1945 you were with the Federal Security Agency?

Mr. MILLER. As Assistant Administrator.

Senator DONNELL. From 1941 to 1945 as Assistant Administrator. Then you succeeded Governor Paul V. McNutt in 1945 as Federal Security Administrator, and you have been that ever since?

Mr. MILLER. That is right.

Senator DONNELL. Now, Mr. Miller, in the course of your work you have, of course, come frequently in contact with the medical profession, both in your Legion work and as Federal Security Administrator, have you not?

Mr. MILLER. Continuously.

Senator DONNELL. And I noted right in the opening paragraph of your statement you have given us this morning you referred to the "truly wonderful kind of medical care we have in our country." That represents your observation on the medical care that has been available in this country, at least to some of the people? Is that correct?

Mr. MILLER. Emphatically.

Senator DONNELL. I am not saying everybody has had this medical care, but your observation on the whole is that the quality of such medical care as has been rendered in this country is excellent? That is correct, is it not?

Mr. MILLER. That is my observation.

Senator DONNELL. Now, Mr. Miller, I referred to the Rhode Island matter. I have before me here the statutes of Rhode Island, namely, chapter 1200, enacted at the January session of the 1942 legislature, 5 years ago, the Rhode Island Cash Sickness Compensation Act. In your work have you had occasion to see that section, that statute itself?

Mr. MILLER. No, sir.

Senator DONNELL. Did you know of its existence?

Mr. MILLER. No, sir.

Senator DONNELL. It has been in existence since some time in 1942, having been enacted, as I say, at the January session of the Rhode Island Legislature.

Mr. MILLER. I have a recollection of having heard from—I think more or less casually—from our associates that such a system was in vogue in Rhode Island, and I think it was suggested in one other State, but I am not sure of that.

Senator DONNELL. This act in Rhode Island was approved April 29, 1942, which is over 5 years ago, and you are not familiar with the operation of that Cash Sickness Compensation Act?

Mr. MILLER. That is correct.

Senator DONNELL. Now, Mr. Miller, you referred to some other States that you have heard——

Senator PEPPER. To save time, will you allow me to interrupt right there? Woud you state what the act is, what the purpose of it is, what it actually provides?

Senator DONNELL. I would not undertake, Senator, to give a complete synopsis of the act. I am not myself able to do that.

Senator PEPPER. I understand that, but what does it provide? I understand that it simply provides compensation to people during the time of their illness. My understanding is it does not have any relationship to the amount of medical care they require during that period, but it just pays their wages or their salaries during the time of their illness. I get my information from the statement of Senator McGrath, one of the authors of S. 1320, who was Governor at the time the act was adopted.

Senator DONNELL. The Senator may well be correct. I have not read the act myself. I observe in section 3 of the act this sentence right at the outset:

> There is hereby created a Rhode Island cash sickness-compensation fund to be administered by the board, without liability on the part of the State beyond the amounts paid into and earned by the fund.

I observe also in section 4 there is an obligation on each employee to contribute—well, it doesn't say there is an obligation. The language is: "Each employee shall contribute."

Senator PEPPER. I understand that is a contributory system.

Senator DONNELL. So Rhode Island has had a cash-sickness-compensation fund with respect to employment after June 1, 1942. The act is quite an extensive act. I observe it is set forth in the Session Act of Public Laws of Rhode Island, 1941–42, pages 564 and following, approved April 29, 1942.

Now, Mr. Miller, you spoke of some other State to the effect that you have heard there is some legislation along similar lines. Do you have in mind what that other State is?

Mr. MILLER. I do not recall, and I did not present that as an assertion, but merely as something that remains in my memory.

Senator DONNELL. You have not studied the legislation of the States of the Union to ascertain whether or not there are any acts comparable to the Rhode Island act?

Mr. MILLER. I have studied some State statutes with particular relation to welfare and public assistance.

Senator DONNELL. But the point I am getting at is that you have not studied the statutes of the various States to see what approaches they have made with respect to insurance, if they have made any such approaches?

Mr. MILLER. That is an accurate statement.

Senator DONNELL. Now, Mr. Miller, in the course of your statement you said that on the basis of these observations; that is, observations that you have set forth on the first page and the early portion of the second page of your statement—"we believe that health insurance is a most effective means by which our people can meet all health needs." I understood that you, in response to one of the questions asked you earlier in your testimony by Senator Smith, by the term "health insurance" are referring to compulsory health insurance?

Mr. MILLER. Yes, sir.

Senator DONNELL. Now, Mr. Miller, have you studied at all the experience of other nations in compulsory health insurance?

Mr. MILLER. I have relied upon the studies made by the specialists in the Social Security Administration and in the Public Health Service, and they have been extensive ones.

Senator DONNELL. But I mean you personally, have you studied the history of compulsory health insurance in any nation of the world?

Mr. MILLER. I would not call it "study." I have read some of the experiences in both England and Germany.

Senator DONNELL. Do you recall what book or books, if any, you have read on those subjects?

Mr. MILLER. They have been pamphlets and other documentary historical material supplied to me by the Social Security Administration and by the Public Health Service.

Senator DONNELL. Do you recall who the author of any of those pamphlets was?

Mr. MILLER. No, sir. They were home reading.

Senator DONNELL. You have not read any books, as distinguished from pamphlets, on the subject of compulsory health insurance, either in England or in Germany?

Mr. MILLER. No extensive documents.

Senator DONNELL. How about New Zealand? Have you read the experience of New Zealand with compulsory health insurance?

Mr. MILLER. I have not.

Senator DONNELL. Have you read anything on the New Zealand compulsory health insurance, pamphlet or otherwise?

Mr. MILLER. Only discussions with my associates on the New Zealand developments.

Senator DONNELL. But I say, though, have you read anything on the New Zealand development at all?

Mr. MILLER. I have not.

Senator DONNELL. You mean by "developments" the developments in health insurance, and I take it you understood that to be my meaning? Is that right?

Mr. MILLER. I have not.

Senator DONNELL. All right. Now, you spoke about the expert advice on which you have relied. On whose expert advice do you rely, Mr. Miller, in formulating this opinion that you express here that health insurance means compulsory health insurance is the most effective means by which our people can meet their health needs?

Mr. MILLER. The Commissioner for Social Security.

Senator DONNELL. Who is that?

Mr. MILLER. Dr. Arthur J. Altmeyer and his immediate associates, and the Surgeon General.

Senator DONNELL. That is Dr. Parran? Is that right?

Mr. MILLER. The Surgeon General and his research advisers.

Senator DONNELL. Mr. Altmeyer has been in Geneva for some time, has he not?

Mr. MILLER. He has been in Geneva for a little better than 2 months.

Senator DONNELL. In addition to Dr. Parran and Mr. Altmeyer, have you relied on the expert advice of anyone else?

Mr. MILLER. Dr. George St. John Perrott.

Senator DONNELL. He is in the Public Health Department, is he not?

Mr. MILLER. Yes. And we get information from Dr. Martha Eliot.

Senator DONNELL. Is Dr. Eliot in the room?

Mr. MILLER. Associate Chief of the Children's Bureau, and others, who, because of our association with the State Department in enterprises germane to our duties in the international field, as a result of the setting up of the United Nations and of prior experiences, conducted researches to find out where the world was going in this field.

Senator DONNELL. Have you conferred with Dr. Isidore Falk at all in formulating your opinion?

Mr. MILLER. I have conferred with Dr. Falk perhaps briefly six times or more in the course of several years that I have been with the Agency.

Senator DONNELL. Six times or more?

Mr. MILLER. Commonly the conversations would be group discussions of these matters in which the talent and experience we had available would all be assembled.

Senator DONNELL. And have you seen any of Dr. Falk's productions or suggestions or his writings on subjects of this general nature?

Mr. MILLER. I have read them in pamphlet form, and particularly his statistical studies, as a part of home reading.

Senator DONNELL. Dr. Falk is in the room this morning, is he not?

Mr. MILLER. Yes.

Senator DONNELL. He, as you know, has been quite active in connection with these health insurance matters? You know that, generally speaking?

Mr. MILLER. I do not know the extent of his activities. If the Senator refers to the studies he has produced, I am sure he has been active.

Senator DONNELL. What is the official connection of Dr. Falk with the Federal Security Agency?

Mr. MILLER. He has been director of the Bureau of Research and Statistics of the Social Security Administration, formerly the Social Security Board.

Senator DONNELL. Now, I have before me a chart issued under date of August 8, 1946, over the facsimile of yourself, Administrator, and I fail to find in here any reference to the Bureau of Research and Statistics. [Producing a chart.]

Senator PEPPER. Is that a Government publication?

Senator DONNELL. This is a chart issued by Watson B. Miller, Administrator.

Senator MURRAY. That is not the one in which Senator Pepper and I are referred to as "Fellow Travelers?"

Senator DONNELL. No; that is not. I don't find any reference here to Dr. Falk's position that you have mentioned. If I have overlooked it, I would like for you to call it to my attention, and tell me, if you don't find it, where it should be.

Mr. MILLER. Senator, this is an over-all chart devised as a study just before adoption by the Congress of the President's Reorganization

Plan No. 2 of 1946, although it is dated a month subsequent to the action by Congress. It is an over-all chart which does not carry with it the bureaus and sections which are pertinent to every one of these major agencies in the Agency.

Senator DONNELL. Mr. Miller, I call to your attention the fact that the date of this is August 8, 1946. Does it not reflect the condition brought about by Reorganization Plan No. 2?

Mr. MILLER. Yes, sir, in an over-all way, Senator.

Senator DONNELL. But there is not any mention on this chart to which I refer to the position occupied by Dr. Falk? That is correct, is it not?

Mr. MILLER. Let me look. I think that is correct, but I can check it here. [Examining the chart.] It does not, apparently, and I am not sure whether it has existed as a separate bureau or whether it is a bureau within one of these bureaus. I think maybe Mr. Mitchell might enlighten me on that.

Senator DONNELL. Mr. Mitchell is to testify, I think, a little later. We will ask him about that. If you are not familiar with that, Mr. Miller——

Mr. MILLER. I would suppose that it should be here as a bureau by itself. I cannot explain the absence of it, except that this is a general over-all chart which shows only the major constituent units of the Federal Security Agency.

Senator DONNELL. The chart does, so far as you observe, generally speaking, set forth the various important bureaus and divisions of the Federal Security Agency?

Mr. MILLER. Oh yes, it sets out in a general way the responsibilities.

Senator DONNELL. And the Bureau of Research and Statistics, headed by Dr. Falk, is considered by you, even though it is not upon this chart, as one of the exceedingly important bureaus in the Federal Security Agency? That is correct?

Mr. MILLER. It would be to any activity of that nature, yes.

Senator DONNELL. Now, Mr. Miller, you have given us your statement this morning, and again I want to say that my question is not intended to be in the slightest degree offensive—but for my information, did anyone collaborate with you in the preparation of this statement which you have given us this morning?

Mr. MILLER. It was roughed out for me and presented to me on a Sunday, and I went over it in detail and made changes which I regarded necessary to be made—Sunday a week ago.

Senator DONNELL. Who roughed it out for you in the first instance?

Mr. MILLER. I think it was Mr. Harry N. Rosenfield, one of my two staff assistants, who is not connected with any bureau of any of the constituent groups or agencies.

Senator DONNELL. Do you know where Mr. Rosenfield secured the information and views that are set forth in this statement that you have given us this morning?

Mr. MILLER. No; I cannot answer that specifically "yes" or "no," but I should like the record to show that Mr. Rosenfield is quite experienced in matters of this nature.

Senator DONNELL. Is he widely experienced in the matter of compulsory health insurance?

Mr. MILLER. I would say that he is more widely experienced than I am, perhaps.

Senator DONNELL. I am asking whether he is widely experienced in matters of knowledge of compulsory health insurance, so far as you know?

Mr. MILLER. That is my opinion.

Senator DONNELL. Do you know yourself whether he has ever read any books on the history of it in any country?

Mr. MILLER. No, sir.

Senator DONNELL. Do you know whether he has ever gone to any country and made an examination there?

Mr. MILLER. No, sir.

Senator DONNELL. You don't know whether he has or has not?

Mr. MILLER. I do not.

Senator DONNELL. He is here in the room, also, is he not, this morning?

Mr. MILLER. He is.

Senator DONNELL. Now, Mr. Miller, some reference was made to S. 1606. That bill was in turn a descendant—child, grandchild, or great grandchild—of S. 1620, was it not, which was introduced by Senator Wagner in the Senate on February 26, 1939, entitled "An act to provide for the general welfare, make more adequate provision for the public health," and so forth?

Mr. MILLER. I believe so, Senator.

Senator DONNELL. Do you know, as a matter of fact, that S. 1620, introduced by Senator Wagner back in 1939, is itself an act which is based on grants to States—and I quote "grants to States for medical care," just as S. 545 is based on grants to States for medical care, quoting from title 13 of that act, S. 1620, and I ask you if you know that to be a fact?

Mr. MILLER. No, sir.

Senator DONNELL. You do not? Well, I call your attention to the fact that on page 2 of that act, title 5, there is entitled "Grants to States for maternal and child welfare," and that on page 16, title 6, "Public Health work and investigation," section 601 of which starts out:

> For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas—

and so forth—

> to extend and improve Public Health work * * * there is authorized to be appropriated—

certain amounts, and—

> sums authorized under this section shall be used for making payments to States which have submitted and had approved by the Surgeon General of the Public Health Service State plans for extending and improving such services.

I assume you will agree that I am reading this accurately; at least, you have no reason to believe otherwise. I call your attention to page 34 of that bill, title 13, entitled "Grants to States for medical care," being a total of some $35,000,000, which, in the language of the concluding sentence of 1301 is as follows:

> The sums authorized under this section shall be used for making payments to States which have submitted and had approved by the Social Security Board hereinafter called the Board, State plans for extending and improving medical care.

So, Mr. Miller, the fact is, assuming the truthfulness of my reading here, which I assure you is correct——

Mr. MILLER. I know it is.

Senator DONNELL. The fact is that the Wagner bill, introduced back there in 1939, S. 1620, proceeds directly on the same theory that S. 545 today proceeds. That is correct, is it not?

Mr. MILLER. Without doubt. I hope the Senator will permit me mildly to remark—this is not argumentative at all—that since 1939 we have had a very lengthy and very increasingly grave experience with the business of compulsory prepaid benefits, which we believe could profitably be applied to the operation of a medical and health service.

Senator DONNELL. I appreciate that point, and also the fact that you undoubtedly believe, or you would not have testified, that the bill now before us, S. 1320, represents what you think are improvements over the predecessor bills, but the point I am making is that the Wagner bill started out in 1939 with the same theory that S. 545 today starts out with. Maybe his ideas have progressed. Maybe improvements have come into S. 1320.

Mr. MILLER. The Senator has made the only point respecting that possibility that I could possibly advance myself.

Senator DONNELL. But at any rate, Mr. Miller, the point I was making is, so that we may have it before the committee for its consideration, that the Wagner bill originally started out on the same basis as S. 545 stands today. I think that is correct.

Senator PEPPER. If you will allow me there, Senator, some people think that man started out as a monkey, but he didn't stay there.

Senator DONNELL. Well, I would hesitate to say that Senator Wagner or his bill started out as a monkey, but I will let the matter stand in the record with the Senator's statement.

Mr. MILLER. I heard it said on the floor of the Senate by a very distinguished member of the upper body, in response to a rather sharp interrogatory the other day that "we live and learn."

Senator DONNELL. Yes, that is true. Now, let us take up some of this bill S. 1320 that we now have before us.

In the first place, Mr. Miller, you made quite an extensive point in your statement—in fact, it is the first main point, I think—appearing on page 3, of decentralization of administration, and you say that S. 1320 very clearly establishes a system of local administration under State-wide plans. I take it by that statement you recognize the importance of local administration? That is correct, isn't it?

Mr. MILLER. We have only one considerable program which is not operated on that basis in partnership with the States and localities, and we espouse that method of operation between the central government and its constituents and the people.

Senator DONNELL. In other words, regardless of whether you favor Nation-wide compulsory health insurance or not, you and I agree, I believe, upon the fact that local administration is of great importance. We agree on that, do we not?

Mr. MILLER. We do, sir.

Senator DONNELL. And by your statement——

Mr. MILLER. The Senator believes that is true, and we so agree.

Senator DONNELL. And by your statement that S. 1320 very clearly establishes a system of local administration under State-wide plans, I take it you mean to express approbation with respect to S. 1320, by reason of its establishment of such system of local administration under State-wide plans?

Mr. MILLER. Quite right.

Senator DONNELL. So you are not censuring S. 1320 for that fact?

Mr. MILLER. Correct.

Senator DONNELL. I take it, however, by your statement about local administration, you do not deny that the Federal Government in S. 1320 is relinquishing the right of ultimate supervision over the entire program Nation-wide, do you?

Mr. MILLER. Not completely. Not more than the Federal Government should relinquish stimulative control and establishment of at least basic minimum standards of various kinds, the determination of complex issues of eligibility in any program as to which it produces plan for financing.

Senator DONNELL. Now, Mr. Miller, I would like to go into this bill even to the extent of being a little tedious, because I think it is very important to go into certain provisions of the bill to find out just what this bill does with respect to decentralization or the contrary, and I call your attention to title II—you have a copy of the bill before you, S. 1320?—entitled "Prepaid personal health insurance benefits." That is the title that relates to the compulsory health insurance. That is correct, is it not?

Mr. MILLER. Benefits and eligibility; yes, sir.

Senator DONNELL. Title II is the title that covers all matters of compulsory health insurance here, does it not?

Mr. MILLER. That is true.

Senator DONNELL. The only remaining title after title II is title III, which is entitled "Development and Expansion of Health Services," and that provides for certain grants to States, does it not?

Mr. MILLER. Title II is divided into several parts.

Senator DONNELL. Yes, title II is divided into a number of parts, beginning with section 201 and running down through section 283. It all relates to prepaid personal health insurance benefits, and that is the compulsory health insurance portion of S. 1320?

Mr. MILLER. That is right.

Senator DONNELL. Now, Mr. Miller, I would like for you to direct your attention, please, to page 38 of the bill, which is within that title, and I call your attention, at the bottom of page 38, section 251, to the language: "There is hereby established in the Federal Security Agency"—and I pause to ask, that is the agency of which you are the head; is it not?

Mr. MILLER. That is right.

Senator DONNELL. "There is hereby established in the Federal Security Agency a National Health Insurance Board." You observe that?

Mr. MILLER. Yes, sir.

Senator DONNELL. Now, I want to ask you some questions a little later about the composition of that board, but we will pass that for the moment. I call your attention now, after the provisions here for the establishment in your agency of a National Health Insurance

Board, to this language over on page 39, beginning at the bottom, line 24 and following:

> The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

I have correctly quoted it, have I not?

Mr. MILLER. Yes, sir.

Senator DONNELL. I take it, Mr. Miller, that the language which I have just read, which in part says the Board shall perform such functions as it finds necessary to carry out the provisions of this title, gives the Board a very important general control over everything in title II, does it not, because it is left to that Board to determine what functions it finds necessary to carry out the provisions of title II?

Mr. MILLER. That is right.

Senator DONNELL. And even though the State has certain functions, which of course States do under this bill, the ultimate determination as to what is necessary to carry out the provisions of the compulsory insurance portion of S. 1320 is left to the National Health Insurance Board, as I have read, is it not?

Mr. MILLER. That is right.

Senator DONNELL. Now let us see if it is right. Let us turn for a minute back to page 39 again and let us read just a sentence ahead of this which I have read, and which contradicts what I have just read to you.

Mr. MILLER. I know what you are going to read.

Senator DONNELL. Of course you do. It says:

> All functions of the Board—

it doesn't say part of them, half of them, three-quarters of them—

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

I have quoted it correctly?

Mr. MILLER. That is right, sir.

Senator DONNELL. So that when we find in the sentence which I first read that the Board shall perform such functions—remember the word "functions"—such functions as it finds necessary to carry out the provisions of the title, namely, the compulsory health insurance title, those functions "shall be administered by the Board under"—not above, not coordinate with, but "under the direction and supervision of the Federal Security Administrator." That is right, isn't it? That is what is says? Is that right? Isn't that what is says?

Mr. MILLER. That is right.

Senator DONNELL. Now, go right ahead with your comments.

Mr. MILLER. I want to say, Senator, that if the Congress finds that there is a contradiction there, it would be easy for the law-making body to correct it. I will say to the Senator, following his own line—what I think is his own line of thought—when I examined this bill and came to the lines the Senator has just quoted, it seemed to set up a sort of a contradiction, and I placed a question mark in the margin for further discussion. I thought it was eligible for further discussion, but I did not go to the liberty of changing the script in this bill.

Senator DONNELL. Now, Mr. Miller, I want to remove what I just called a contradiction, because I don't think that ultimately there is any contradiction. It is if you just stop with what I first read to you, namely, "The Board shall perform such functions as it finds necessary to carry out the provisions of this title." It would appear that the ultimate authority resides in the Board, but as I have indicated, that is contradicted by this other sentence which precedes it, which says that all those functions shall be administered under the direction and supervision of the Federal Security Administrator, but as I see it, the two sentences can be and should be and are properly read in conjunction and juxtaposition, and giving due effect to both sentences—in other words, what it means is that the Board shall perform such functions as it finds necessary to carry out the provisions of the title, to make all regulations, and so forth, but it is provided that all those functions shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

So I think, Mr. Miller, that under the theory of this bill, S. 1320, there is no occasion to change the language, and so far as I am personally concerned, on the matter of legal construction I see no necessity for the question mark on the border. I do, however, raise this point, and I think you will agree with me, that under the terms of this bill, particularly pages 39 and 40, from which I have read to you, the ultimate determination of what is to be done in the administration of the compulsory health insurance provided by that bill, comes back to the Board and then right up to one man, and his decision is the decision that counts, and that one man is the Federal Security Administrator. That is correct, is it not?

Mr. Miller. I am not trying to fence with the Senator, of course. I am not given to trickery or evasion.

Senator Donnell. I know you are not, and I do not imply that.

Mr. Miller. I believe that this means—and I raise the question only for the purpose of discussion here, as you have raised it—that there must be vested some place the authority for developing standards and the necessary circumscription which should only go so far as to assure that the objects of the bill are carried out. I said in my presentation that no administrator could get along with arbitrary or capricious action, and I am one who thinks he should not be permitted to get along in a capricious manner with Congress looking at him, the people looking at him, and even if they were not, he ought not to do it.

Senator Donnell. I agree with you there should not be any capricious action, but the point I am getting at is that while you make in your statement as your first main point, and you devote several pages of your statement to it—two pages anyway—to the decentralization of administration, the actual fact is that, regardless of all these provisions about State administration, the ultimate decision on everything comes back up to one man, the Federal Security Administrator. That is correct, is it not?

Mr. Miller. It comes to the Congress through him.

Senator Donnell. It comes to him under the provisions of this bill, so that if Congress passes this bill, the Federal Security Administrator is where the ultimate authority resides. That is correct, is it not?

Mr. Miller. You cannot read into this part of the section or any place in this bill that the Administrator or the Board has the right to go out and station policemen, or should go out and station policemen or enforcement people in these States or in these communities.

Senator DONNELL. That is not what I am talking about, Mr. Miller. What I am saying is, just as I said a moment ago, and I want to ask you if you do not agree with this, that the ultimate authority under this bill, under title II—which is the Compulsory Health Insurance Title—the ultimate authority resides in one man, the Federal Security Administrator?

Mr. MILLER. Certainly for the production of regulations and the development of standards.

Senator DONNELL. It is true, and I quote at line 22, page 39, again—and I am not laboring the point further except to read this—

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

We agree that that is in the bill, is it not?

Mr. MILLER. That is right. Is there a feeling, sir—if I may ask—that somebody should be held responsible to this body under the people for the administration of a piece of legislation which is as important and complex as this?

Senator DONNELL. Certainly there should be some responsibility somewhere, but the point I am making is this: You have emphasized here very clearly and very excellently this point of decentralization of administration. The point I am making is that while there is all this language here over page after page, State administration, declaration of policies, State plan of operation, State this and State that, and so forth, that when you get right down to the meat in the coconut, page 39, line 22, to line 4 on page 40, the ultimate authority resides right in one man, and he is down here in Washington, D. C., and he is the Federal Security Administrator. That is true, is it not?

Mr. MILLER. I am glad to admit that.

Senator DONNELL. All right. Now, Mr. Miller, let us just consider a minute—and this is the reason I asked you what I hope you did not take any offense at, about your early experience, and I want to repeat that I have the utmost respect for your experience; I have no criticism whatever of it, but the point I am making is, and that I want to present for your consideration, just as it will be presented to this committee and to Congress—whether it is advisable to vest all the power in the first place in Washington, D. C., at all, whether that is advisable; and in the second place, is it advisable to vest it in an individual—not you particularly, any more than anybody else—but in some individual who is not required by law to possess particular, specific qualifications? That is the point I am leading up to, and with all due respect to you, Mr. Miller, I want to point out, and I ask you again for the record, as I have in the past, you are not a physician, are you?

Mr. MILLER. No, sir.

Senator DONNELL. And, of course, you make the point, and you make it clearly and concisely and excellently, that, in your opinion, a doctor should not be at the head of this. That is your judgment?

Mr. MILLER. That is right.

Senator DONNELL. That is your thought. Now, we may never agree on that, and I am not expecting that you will agree with everything

I say here this morning, nor ask you, but I would like to call your attention, if you will turn to page 14 for a moment——

Mr. Miller. Senator, I think I have some truly extraordinary qualifications for handling this job, a job of this kind, and if the Senator will go into it with me sometime I will try modestly to recite those experiences.

Senator Donnell. Now, Mr. Miller, I am not criticizing you in the slightest. I have every respect for Watson B. Miller. I know him and like him, and we have got along fine in the past, and I think will in the future.

Mr. Miller. That goes both ways.

Senator Pepper. And may I—I would like at this time to hear the statement of why you think you are qualified to administer the duties of the office you hold.

Senator Donnell. I think that is very proper, and we would be very happy to have him do that.

Mr. Miller. I have had somewhat larger administrative and business experience than I have attempted to expose here, a very varied experience not only in this country but in foreign countries. I have traveled a good deal, and for the 18 years that I was chairman of the American Legion's rehabilitation committee——

Senator Donnell. Pardon me, Mr. Miller—this is not meant to interrupt you rudely at all, but I would like somewhere, before you proceed, I just want to mention, of couse, that this bill in no place, of course, makes mention of any one individual, and there is no assurance in this bill as to the qualifications of your successor over a period of years, whether he will have the same qualifications as you have or not.

Mr. Miller. I have conceded, Senator, the right of any member of this body to develop the point that he is working out with me, but which is evidently to reinforce his feelings that the head of an agency of this kind should be a physician. I have not that viewpoint.

Senator Donnell. Proceed as Senator Pepper suggests. I think his suggestion is excellent.

Senator Pepper. To start with, you were appointed by the President of the United States?

Mr. Miller. Yes, sir.

Senator Pepper. Who was chosen by the people of the United States to discharge the duties of his office?

Mr. Miller. Yes, sir.

Senator Pepper. And you were confirmed by the Senate of the United States?

Mr. Miller. Yes, sir.

Senator Pepper. And you have made reports from time to time to the President of the United States and to the American Congress relative to the discharge of your duties?

Mr. Miller. Yes, sir; special and regular reports.

Senator Pepper. Under the law and under S. 1320 your successor would be appointed by the President of the United States and confirmed by the Senate of the United States?

Mr. Miller. I think he would be.

Senator Donnell. Of course, Mr. Miller, when you were appointed, S. 1320 was not then in existence and is not yet the law of this land, so that when you were appointed by the President the functions of a compulsory health insurance director were not in the office to which you were appointed? That is correct; is it not?

Mr. MILLER. That is right.

Senator DONNELL. Now proceed, Mr. Miller, with your qualifications.

Mr. MILLER. I will start by saying that I had, for just an average, very modest American citizen, a rather varied and sometimes colorful experience in this country and other countries. I have traveled somewhat widely. When I was appointed, somewhat against my own volition, to head up the very extensive medical, administrative, and claims section of the American Legion, with a budget of sometimes a quarter of a million dollars a year to do business with, I recognized that the further we departed from the First World War in terms of time, the more important position medicine would assume. I don't have to point out the reason for that, except maybe to say that the sources of evidence die out; you have to study closely considerations of etiology, causative factors in medicine, considerations which might effect an identity between something that occurs in a man's medical history 20 years after his departure from service with something that occurred in service, though lately called by quite a different name. Consequently, one of the first things I did was to surround myself with full-time medical men, and establish an advisory group, such as is set up in this bill, of the best physicians and specialists in the world. Thus for some 20 years I was led gradually, though a layman, through many medical experiences, divorcing myself from the notion, as I said a while ago, of invading the medical profession. I found it to have a very great interest for me, and I ventured into operating theaters and had personal observation of at least 2,000 major physical operations, and occasionally went to the autopsy table, which is something less pleasant. All this instruction was valuable to my work then and now.

I studied X-ray interpretation. I studied anatomy and physiology, and I did my best to acquaint myself with the job I had on hand. After leaving the Legion, I devoted myself to that very diligently as Assistant Administrator and as Administrator of the Federal Security Agency. That is a sketchy outline.

Senator PEPPER. Let me interrupt there. How were you chosen by the American Legion, Mr. Miller? I mean were you appointed by the commander or elected by a convention?

Mr. MILLER. I was appointed by John Quinn of California, in 1923.

Senator PEPPER. And how long did you remain in office; how long after that?

Mr. MILLER. Eighteen years.

Senator PEPPER. Were you appointed then by subsequent commanders?

Mr. MILLER. There was never any reappointment.

Senator PEPPER. You just remained?

Mr. MILLER. It was a career job.

Senator PEPPER. It was a career job, and you remained in that position under subsequent commanders of the American Legion?

Mr. MILLER. Yes; and in that job we were associated with many officials in Florida, Montana, New Jersey, Missouri, some of them physicians and dentists.

(Discussion off the record.)

Senator PEPPER. Did you, during the time you were chairman of the rehabilitation committee of the American Legion, have any action taken for any experience, conducted by either the commander of the Legion or by the Legion in convention, either in commendation or in condemnation of your services as chairman of the rehabilitation committee?

Mr. MILLER. Well, the national executive committee of the American Legion, which constitutes membership of something like 3,000,000 people, developed and approved the budget, and I think my career service was generally recognized as being diligent and sincere and effective. I think it was conceded that we did not do an apathetic job, but we established at that time a will to do, with far-reaching effect. We were recognized as the advisers to the Congress, and through these years I had the responsibility of perfecting and presenting what might be the technical phases of proposed legislation. I always tried to come to the Congress, not with the notion that we had a lot of votes in the American Legion, but with something based upon either historical or actual experience which would justify a presentation of such a piece of legislation.

Senator PEPPER. Will you allow me one other question, Senator? Since you were speaking about the rehabilitation of veterans, I want to refer to the fact that at the present time the man in charge of the Veterans' Administration is Gen. Omar Bradley, is he not, and the Veterans' Administration has a colossal health program under it embracing many hospitals, many nurses, many technicians in its employ, and one of its principal functions is to look after the physical rehabilitation of the veterans and furnish hospital and medical care to them?

Mr. MILLER. It is those hospitals in which I got my medical instruction.

Senator PEPPER. Yet Gen. Omar Bradley is not a doctor; is he? He is a professional soldier; is he not?

Mr. MILLER. I know he is a professional soldier, and I am sure he is also a very good one, but I suppose he is not a doctor, although I don't know. I have visited many hospitals in those countries in relation to the care of veterans in foreign countries, for the purpose of adding to my knowledge, just as I now occasionally sally out into the States and make inquiries as to how we are doing. That is true of many other types of clinical instruction with which I was not familiar. I have studied hospital administration from the time of their construction, including landscape gardening, drainage, utilities, laundry service, production of food, transmission, storage, and service to the bedside, laboratory facilities, nursing, and everything that has to do with the conduct of a clinical institution of which all Americans should be proud, providing an increasingly effective line of hospitals in the service of veterans.

Senator PEPPER. Your conclusion, then, Mr. Miller, is that you had a rather unique opportunity to see this whole subject in perspective, and that is what an administrator needs to have in the administration of a large activity of that sort?

Mr. MILLER. Well, since this matter has come under discussion, I don't want to be unduly modest about it, and I am sure Senator Donnell would not want me to be, but I have been a source of some wonder to the profession as to the things a layman could pick up and become acquainted with. I said laughingly to the Senator from Webster Groves one day that many doctors might have given me an M. D., but I am afraid some might add an A between the M and the D.

Senator DONNELL. Now, Mr. Miller, I take it you feel that your experience in regard to X-ray matters, attendance at autopsies, 2,000 cases that you had observed in your studies of hospitals, your studies of nursing—that all of that tends to make you more efficient than you otherwise would be?

Mr. MILLER. I think that is the reason for my being selected by the President for my job.

Senator DONNELL. But I say, you think that all those experiences tend to make you better qualified than you otherwise would be to perform the duties under S. 1320? Is that right?

Mr. MILLER. Without doubt.

Senator DONNELL. Now I call your attention to the fact, Mr. Miller, that there is no requirement in S. 1320 that the man who shall succeed you shall have any of these experiences or qualifications which you regard as particularly and peculiarly qualifying yourself, and that is the point I am making. I would say that you have had an extraordinary experience, Mr. Miller, in many respects, as you have indicated, but what we are discussing here is a bill that does not say that the authority herein shall be vested in Mr. Watson B. Miller. It says it shall be vested in the Federal Security Administrator, and my point is that there isn't anything in the statute, anything in the law of this country, which requires that the Federal Security Administrator shall have had any of those experiences. The next one may or may not have had them.

Mr. MILLER. The President appoints and the Senate ratifies, does it not?

Senator DONNELL. It is put up to the President to make the appointment, and it is confirmed by the Senate, that is true; but the point I am getting at is that there is no requirement in the statute that the Federal Security Administrator shall have had all this vast experience which you regard yourself as of great importance in your own case. That is true; is it not?

Mr. MILLER. That is right. I assume that any appointee would have or would acquire knowledge of all the phases of the job, medical and otherwise.

Senator DONNELL. Now, Mr. Miller, I want to call this to the attention of the committee, to have it in this record so we will not in any sense overlook it, one of the fundamental things that I want to bring up this morning, not particularly the question as to whether this man should or should not be a doctor—not that at all—but the point is that this bill vests ultimate authority where? Not in the States at all, but in Washington, D. C., and my point is that it is unwise to vest such vast authority in the National Government as distinguished from the States; that that thought was recognized in the first Wagner bill that I have referred to, and, furthermore, that it is not only unwise to so vest authority in Washington, but it is unwise to vest it in one individual, regardless of who he may be, a doctor or nondoctor, or whatever he may be.

Mr. MILLER. Is there unwisdom—may I ask a question?

Senator DONNELL. Certainly.

Mr. MILLER. With complete respect, of course—is there any unwisdom in the selection of an individual whom the Congress and the people can particularly hold responsible for doing the job? Is there any unwisdom in the present interesting and somewhat complex mosaic of the Federal Security Agency to have one man who will carry those responsibilities, put everything he has, all his diligence and all his heart into them, and stand ready at all times to be responsible and responsive to the Congress? I think not.

Senator DONNELL. That is your judgment, and, of course, you have had wide experience, and your judgment is entitled to careful consideration; but the point I am making is that here is a vast new experiment, one that you have not personally studied at all. You are not familiar with the Rhode Island experience, which is not compulsory health insurance in the sense that this bill is at all, does not go anywhere near as far as this bill—you have not studied the Rhode Island situation, you have not studied the situation in foreign countries, and yet here is a bill behind which you have put your opinion—and you are entitled to it, of course—which vests the authority ultimately over the entire administration of a vast new compulsory health insurance plan in one individual in Washington, D. C., and an individual who, so far as I know, is not required by the statute to have any qualifications peculiarly qualifying him for that compellingly important position.

Mr. MILLER. I would do that, and I would like to add, if I may, that it is not within human comprehension or intellectually possible for a person with this kind of responsibility personally to study every detail, personally to determine the accuracy or the effective justice of every proposal that comes about. The Senator will concede that.

Senator DONNELL. I think you are correct.

Mr. MILLER. And in your very busy lives you have to have expert professional assistants—one whom you would dislike to lose sits here today, who worked with me for some years before he came to the Capitol, to Congress. I did not like to lose him.

Senator PEPPER. Will you allow me to interrupt to inquire who that is?

Mr. MILLER. Dr. Cornell.

Senator PEPPER. Senator, I respectfully submit that the inquiry made by the able Senator from Missouri is a matter addressed to argument rather than information, but I want to observe that in the Constitution of the United States, in section 5 of article I, there is no qualification whatever laid down for membership in the Congress of the United States, the two bodies of the Government intrusted with the enactment of the laws of this great land. It says each House shall be the judge of the election returns and qualifications of its own members. The Constitution saw the wisdom of the membership of each side deciding whether a man elected by the people was qualified or not.

Senator DONNELL. Will the Senator yield for just an observation? May I call attention to the fact, however, that Congress consists of 531 men, whereas, the bill centralizes authority in 1 man.

Senator PEPPER. But I suggest, if I may, along the line of the argument already made by the witness, that we have got the discretion of the President of the United States and the confirming power of the Senate, which I submit is an adequate test of Congress. Now, I want also to suggest that under article III of the Constitution there is a provision for the judges of the United States. I do not know whether the statute—I don't have the statutes here before me, and I don't recall whether the statutes prescribe the requirements as to whether Judges of the Supreme Court and judges of the inferior courts shall be lawyers or not, but it is interesting that the founders, the framers of our Constitution, provided for our whole judicial system, for our judges in the following language, article III, section 1:

> The judicial powers of the United States shall be vested in one Supreme Court and in such inferior courts as the Congress may from time to time ordain and establish. The judges, both of the Supreme Court and of the inferior courts, shall hold their offices during good behavior, and shall at stated times receive for their services compensation which shall not be diminished during their continuance in office.

The founders of the United States Constitution, apparently, so far as the Constitution is concerned, left it to the President and to the confirming power of the Senate to assure the country that the judges of the Supreme Court and all inferior courts would be competent to discharge their duties, but it did not require that they be lawyers.

Senator DONNELL. I direct the able Senator's attention to the fact that the fundamental point which I have been driving at this morning, earlier, this more detailed point is to the fact of the unwisdom of centralizing authority in any one individual, regardless of whatever statutory qualifications may be provided. There is a subsidiary point, though, to which I am now going to address myself, this matter of the peculiar type of individual who is to discharge the duties prescribed under the proposed S. 1320.

Senator PEPPER. There is nothing in this language to prevent the President from requiring that the incumbent of this office must be a doctor. That is left up to the President and to the Senate.

Senator DONNELL. However, the bill itself, which is the law which determines what shall be done under compulsory health insurance, does not contain a provision making it mandatory that any particular qualifications would be possessed by the Federal Security Administrator.

Senator SMITH. I might announce at this point that under the rules of the Senate we will recess at 12 o'clock until we obtain consent of the Senate to continue this hearing, so at 12 o'clock we will recess for 2 or 3 minutes until we get the consent which has been asked for.

Senator DONNELL. Now, Mr. Miller, referring to the particular duties that will devolve upon the Federal Security Administrator under this bill, I would like to call your attention, if you will turn to page 14——

Senator SMITH. We will recess for 3 or 4 minutes, until I am advised that consent has been given for us to continue.

(Whereupon, at 12 o'clock noon, a short recess was taken.)

Senator SMITH. The committee will come to order, and we will resume the testimony of Mr. Miller.

Senator Donnell. Mr. Miller, when we recessed I was just about to direct your attention to lines 15 and following on page 14 of the bill. I call your attention that that particular language is contained in the section which is entitled "Physicians and Dentists; Specialists":

> Any individual who is a physician or a dentist legally authorized in a State to render any services included as general medical services or general dental services shall be deemed qualified to render such services in that State as benefits under this title. Any such individual who is found to possess skill and experience of a degree and kind sufficient to meet standards established for a class of specialist services shall be deemed qualified to receive compensation for specialist services of such class as benefits under this title.

Then I call your attention to this:

> The Board, after consultation with the Advisory Council, shall establish standards as to the special skills and the experience required to qualify an individual to render each such class of specialist services as benefits under this title, and to receive compensation for such special services.

Now, Mr. Miller, I ask you whether or not you regard it as of importance that a Board which is to establish standards as to special skills and experience required to qualify an individual to render specialist services as either a doctor or dentist, would be qualified better to establish those standards if that Board had doctors upon the Board?

Mr. Miller. Yes, sir.

Senator Donnell. Now I call your attention to this fact, however, that while this language that I have read provides that the Board shall establish these standards, again, to go back to page 39, line 22—

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

I take it, therefore, that under this bill, S. 1320, as thus written, the ultimate determination of standards as to the special skills and experience required to qualify an individual to render these various physician and dental specialist services, the ultimate power goes back through the Board back into the hands of one man, the Federal Security Administrator, who is not required to be a doctor. You would agree to that statement of fact, would you not?

Mr. Miller. That is right.

Senator Donnell. Now, I would like to call your attention to a few other illustrations, if you will turn, please, to page 7 of the bill.

Mr. Miller. But I remarked as to this type of authority, however, that Congress extended, for example, to the Veterans' Administration recognition of the specialist groups.

Senator Donnell. Well, at any rate, the language reads as I have given it to you in my question?

Mr. Miller. Yes. I would suppose, though, that what would happen, there, if I had anything to do with it, is that the recognition would be made with close reference to the 19 specialist boards that exist in this country for the particular purpose of recognizing specialists in one or another branch of medicine.

Senator Donnell. However, Mr. Miller, there is nothing in this bill that requires anybody to recognize those 19 boards.

Mr. Miller. I concede that.

Senator Donnell. Now, Mr. Miller, before I call your attention to page 7, however, I should mention this: the Board after consultation with the Advisory Council—now, let us just take up this matter of the Board for a minute. Will you turn, please, to page 38 and observe the composition of the Board, the National Health Insurance Board, to be composed of five members, three of whom shall be appointed by the President, by and with the advice and consent of the Senate, and the other two of whom shall be the Surgeon General of the Public Health Service and the Commissioner for Social Security? Now, it will be observed there that two are the Surgeon General and the Commissioner for Social Security. The Surgeon General of the Public Health Service is, of course, a doctor?

Mr. MILLER. That is correct.

Senator DONNELL. Who is the present Commissioner for Social Security?

Mr. MILLER. Arthur J. Altmeyer.

Senator DONNELL. Is he a physician?

Mr. MILLER. No, sir.

Senator DONNELL. He is not required by law to be a physician?

Mr. MILLER. No, sir.

Senator DONNELL. Now, as regards the appointive members of the Board, these three to be appointed by the President, I call your attention to lines 6 and following—

> At least one of the appointed members shall be a doctor of medicine licensed to practice medicine or surgery in one of the States.

That is what it says, is it?

Mr. MILLER. Yes, sir.

Senator DONNELL. So, of the five members of the National Health Insurance Board, only two are, by this law and the existing law relative to the Surgeon General, required to be doctors? That is true, isn't it?

Mr. MILLER. That is right.

Senator DONNELL. And the other three do not have to be doctors?

Mr. MILLER. That is right.

Senator DONNELL. Now, when we were talking a little while ago about page 14, about the Board, of which only two out of five have to be doctors, the Board being required to establish standards as to special skills and experience required to qualify an individual to render each such class of specialist services, I read also something about an Advisory Council, after consultation with the Advisory Council.

Mr. MILLER. In line 15.

Senator DONNELL. Yes. In that connection I would like to direct your attention to page 42 of the bill, which tells us something about the Advisory Council. We start right at the top of that page—

> There is hereby established a National Advisory Medical Policy Council (referred to in this title as the "Advisory Council").

Now, the Council consists of whom?

> The Chairman of the Board, who shall serve as Chairman of the Advisory Council, ex officio, and 16 members, appointed by the Federal Security Administrator.

That will be 17 people on that Council. Who appoints the 16 members?

Mr. MILLER. The Federal Security Administrator.

Senator DONNELL. Yes, it says right there in lines 6 and 7—

> appointed by the Federal Security Administrator.

So here we have this set-up: That we have a Board of five persons, only two of whom have to be doctors, and we have an Advisory Council of 17 persons, 16 of whom are appointed by the Federal Security Administrator, and then the ultimate authority over the Board is vested in the same Federal Security Administrator, who appoints 16 of the 17 persons who advise him. That is the situation in this bill.

Mr. MILLER. That is right, but this will not be the only board that we have appointed, and full recognition has been given in the appointment of all of these Advisory Council members and boards to the interests which are particularly pertinent to the activity. I see little in the proposition there that are permissive elements in this bill. You certainly have got to place some reliance in the man doing the job. If he went far astray you would hear from the people.

Senator SMITH. Of course, you are giving extraordinary powers to him in this bill. I think that is the reason Senator Donnell is asking the questions.

Senator DONNELL. And for the further reason that under this bill, as I read it back here at the start, where it talks about the Advisory Council and talks about the Board after consultation with the Advisory Council, the casual reader of that bill would get the idea that there is an ample safeguard, that the Board can do these things only after consultation with the Advisory Council, but when you get down to pages 39 and 42, you find that in the first place the Board cannot do anything except under the direction and control of one man, the Federal Security Administrator, and that this Advisory Council, which would appear at first glance here to be such a protection and help, is an Advisory Council of 17 men, 17 persons, 16 of whom are appointed by the one man who has ultimate power of decision.

May I read a little further, beginning in line 7:

> At least 8 of the 16 appointed members shall be individuals who are familiar with the need for personal health services in urban or rural areas, and who are representative of the interests of individuals eligible for benefits under this title, and at least 6 of the members shall be individuals who are outstanding in the medical or other professions concerned with the provision of services provided—

and so forth.

Mr. MILLER. What would you do in the case of the Hill-Ball-Burton bill, Senator?

Senator DONNELL. I was coming to the Hill-Burton bill. You appointed the Advisory Council under that bill, didn't you?

Mr. MILLER. Exactly under the terms of the statute.

Senator DONNELL. Did you appoint Mr. Michael Davis one of the members of the Hospital Advisory Council?

Mr. MILLER. Yes, sir.

Senator DONNELL. Mr. Michael Davis is on the Committee for the Nation's Health, isn't he?

Mr. MILLER. Well, I don't know.

Senator DONNELL. Well, you know that Mr. Davis has been very active in a number of different organizations that have had representatives here appearing and giving testimony, that had close contact with Dr. Boas, Dr. Frothingham, Dr. Butler, and various other persons mentioned, participating in the testimony? You know that to be true, do you not?

Mr. MILLER. I believe it is true.

Senator DONNELL. And you know that Mr. Michael Davis is a registered lobbyist, do you not?

Mr. MILLER. No, sir.

Senator DONNELL. You would not say that is not true, but you don't know? Is that the situation?

Mr. MILLER. My answer was that I don't know.

Senator DONNELL. You don't know one way or the other?

Mr. MILLER. That is right.

Senator DONNELL. Now, Mr. Miller, going back here, if you will, please, to page 7 of the bill, let us take up another illustration of what type of ultimate authority rests in the Federal Security Administrator under this bill. At the bottom of page 6 it says "Hospital services." That is one of the personal health services to be made available as benefits as are medical services, dental services, home nursing services. Then come hospital services, which consist of hopitalization, including necessary nursing services—

> and such physician, laboratory, ambulance, and other services in connection with hospitalization as the National Health Insurance Board (hereafter referred to as the "Board"), after consultation with the National Advisory Medical Policy Council (hereinafter referred to as the "Advisory Council"), by regulation designates as essential to good hospital care for a maximum of 60 days in any benefit year.

You observe that, do you not?

Mr. MILLER. I think the hospitalization can be extended beyond that in an emergency.

Senator DONNELL. Well, maybe it can. I don't recall, but at any rate—yes, it does, down at the bottom there, lines 12 to 16 on that same page, page 7—

> Whenever the Board, after consultation with the Advisory Council, finds that moneys in the account (established by sec. 71) are adequate and that facilities are available, it may by regulation increase the maximum days of hospitalization in any benefit year.

Mr. MILLER. I don't remember exactly the reference.

Senator DONNELL. The point I was directing attention to is not the matter of 60 days, but the point I was directing your attention to is that this Board, this National Health Insurance Board, however, acting at all times under the direction and supervision of the Federal Security Administrator, can, by regulation—in fact, I think "shall" by regulation, or "may" by regulation—designate "as essential to good hospital care," such hospitalization, nursing services, physician, laboratory, ambulance, and other services as it, after consultation with the Council—which is again appointed, 16 out of the 17, by this one man—the top of a system—determines to be proper.

Mr. MILLER. That is right. That is exactly the system that prevails right now in our Agency with its medical responsibilities, including something like two score or more hospitals and such other vital health responsibility. The Administrator has the ultimate responsibility for this and the nonmedical phases.

Senator DONNELL. The point I am getting at—and of course, you have mentioned yourself, your great experience with hospitals, which I think you mentioned because you thought it had a bearing on your qualifications under this act.

Mr. MILLER. I did, with some reluctance.

Senator DONNELL. But you mentioned it, and properly so. But the point I am getting at is that there is vested ultimately under this bill, through the Board, with the assistance of a council of 17 members, 16 being appointed by the Federal Security Administrator, ultimate authority to determine by regulation what hospitalization, what nursing services, what physician services, what laboratory services, what ambulance, and what other services are proper and essential to hospital care. That ultimately goes back to one man, the Federal Security Administrator, who is not required to know anything about any of these matters, so far as the bill says or any other provision of law says. That is true, is it not?

Mr. MILLER. I think that is eminently proper, Senator, but he would not last long unless he acquainted himself with those things.

Senator DONNELL. Now, I call to your attention page 47 of the bill. This is a section which pertains to the very important subject of the administration of the title in rural areas. It is section 256 and reads like this, page 47, line 7:

Mr. MILLER. Let me see it, please. [After examining the bill.] Yes; that is right, the latter part of the important section 256.

Senator DONNELL. Yes; line 7. It is referring here to the administration of the title where special consideration shall be given to problems of rural areas and so forth.

> The Board—

which, of course, again, as I have indicated at numerous times, is subject to the direction and supervision of the Federal Security Administrator—

> is authorized to make such regulations, after consultation with the Advisory Council—

16 of the 17 members of whom are appointed by the Federal Security Administrator—

> as may be necessary to promote and facilitate the accomplishment of the objectives of this section.

Mr. MILLER. Those set out particularly in section 256 (a), I take it.

Senator DONNELL. Yes; that is right, 256 (a). Now, Mr. Miller, that is another very vast power which is vested in the Federal Security Administrator ultimately, isn't it?

Mr. MILLER. Yes, sir.

Senator DONNELL. And in addition to that, at line 15 of page 47—

> The Board—

and I supplement that by saying, which acts again under the direction and supervision of the Federal Security Administrator—

> shall include in its annual reports to Congress recommendations concerning such further legislative measures as it considers desirable to assure to rural people an equality of opportunity to obtain the personal health service benefits available under this title.

That devolves a very important and far-reaching function ultimately on the Federal Security Administrator too?

Mr. MILLER. That is right.

Senator DONNELL. Now, I would like to ask you—direct your attention to just a very few further illustrations. Will you turn, please, to page 15 of the bill, under the subject "Nurses"? I will read to you this language, and I read it without comment, though you may have leave, of course, to comment upon it, but directing your attention to the point that here again, to the fact that ultimate direction and supervision is in the one man, I call to your attention that vast power given to him by section 212:

> Any individual shall be deemed qualified to render home nursing service in a State as benefits under this title if such individual is (a) a professional nurse registered in such State, or (b) a practical nurse (1) who is qualified as such under the State standards or requirements, or, in the absence of State standards or requirements, is found to be qualified under the standards established by the Board—

now, I interpolate a parenthesis (which acts under the direction and supervision of the Federal Security Administrator)

> after consultation with the Advisory Council—

I would like to put in another parenthesis there (16 of 17 members of which are appointed by the Federal Security Administrator)

> and with nursing agencies.

That is the language, is it not, of this portion of that section 212?

Mr. MILLER. Yes, sir.

Senator DONNELL. Now, I want to mention just a similar illustration. I will not go into detail, but with respect to what constitutes hospital care, there is also a provision over on page 16 in regard to agreement with individual practitioners, hospitals, and others, who may enter into an agreement—it says an individual may enter into an agreement with a State agency—

> which, in accordance with part D, has assumed responsibility * * * to * * * furnish such class or classes of services as benefits to individuals.

That refers to the making of agreements with State agencies.

I think the section I had in mind, however, is not this section but is section 214, just ahead of it, and that is an auxiliary service where it says:

> Any person (as defined in sec. 281 (1)) who is qualified under State standards or requirements to furnish a class of service included as auxiliary services, or, in the absence of State standards or requirements, is found to be qualified to furnish a class of such services under standards established for such class by the Board—

and I add a parenthesis (under the direction and supervision of the Federal Security Administrator)

> after consultation with the Advisory Council—

another parenthesis (16 of the 17 members of which will be chosen by the Federal Security Administrator)

> shall be deemed qualified to furnish such class of auxiliary services in that State as benefits under this title.

The language is as I have read, with the interpolations by myself.

Mr. MILLER. Auxiliary services are described in another part of the bill.

Senator DONNELL. I also call your attention, Mr. Miller, on page 36, that the Federal Government may, under certain circumstances, stipulate, in the event that a State fails to approve a plan of operation—again may I read to you this language, line 10, page 36:

> If a State has not, prior to July 1, 1948, submitted and had approved a plan of operations, the Board—

parenthesis again, I will insert: (Under the direction and supervision of the Federal Security Administrator)

> shall notify the governor of the State that the Board—

I insert the parenthesis: (under the direction and supervision of the Federal Security Administrator)

> will be required to administer this title in the State.

Then "The Board," and so forth—

> If within 60 days after such notification to the governor the State has not submitted an approvable plan, the Board—

with the same parenthesis—

> shall undertake the administration of this title in the State—

the parenthesis put in again by myself.

Now, I will not go further in the illustration.

Senator MURRAY. For the purpose of shortening the proceedings I suggest that those interpolations be considered as being inserted in all the questions asked by the distinguished Senator.

Senator DONNELL. Only where I insert them.

Senator MURRAY. Wherever they have been inserted, that they be considered as reinserted in each recurring question.

Senator DONNELL. No; I would prefer to frame the question as each question arises.

Now, Mr. Miller, did you give any special consideration in this bill to whether or not free choice is given to the patient, under this bill, of selection of a doctor?

Mr. MILLER. Yes, sir.

Senator DONNELL. And did you make a statement on that in what you gave to us here this morning?

Mr. MILLER. I think perhaps in a very brief way.

Senator DONNELL. I don't recall. Perhaps I didn't hear that.

Mr. MILLER. The benefit of free selection and maximum independence of physicians; their right to reject or accept.

Senator DONNELL. Where is that in your statement? I didn't get that.

Mr. MILLER. It might not be here. The Senator would have noted it, I expect. Senator Smith, do you remember it?

Senator SMITH. I remember it in the statement of a previous witness with reference to page 7, "Participation of professional practitioners." Is that what you have reference to?

Mr. MILLER. "Professional rights and responsibilities, amount of payment for services, local professional committees." An important consideration in any medical-care program is the effect on the right and prerogative of both the provider and the recipient of care. I think that statement is headed toward the right of free selection, free acceptance or rejection.

Senator DONNELL. Did you find anything in your statement there that is specific on the point of free choice of doctors by the patient?

Mr. MILLER. I will look a little more carefully.

I find here on page 7 under "Protection of patients" the statement:

> Legislative assurances are provided for patients in the program in a variety of manners: free choice of doctors (sec. 203).

Senator DONNELL. I am glad that you made that point, and I want to call your attention to section 203, and I think this a very important point. Section 203 reads, the relevant part of it—there may be some other part that some may think relevant, but I will read only the part that at the moment I see has relevancy:

> Every individual eligible for personal health service available under this title may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection.

You observe that?

Mr. MILLER. Provided that the practitioner——

Senator DONNELL. Yes—

> *Provided,* That the practitioner, medical group, hospital, or other person has agreed under part B to furnish the class of services required and consents to furnish such services to the individual.

Now, I call your attention, first, to the fact that this outright statement in your prepared statement, which you read here this morning—

> Legislative assurances are provided for patients in the program in a variety of manners: Free choice of doctors (sec. 203)—

is provided by the proviso in section 203, namely—

> *Provided,* That the practitioner, medical group, hospital, or other person has agreed under part B to furnish the class of services required and consents to furnish such services to the individual?

Mr. MILLER. Of course, it is.

Senator DONNELL. Now, Mr. Miller, I take it therefore that there is no mandatory provision requiring every doctor in the United States or in the District of Columbia to consent to furnish the class of services or to furnish any service under this bill? That is correct, is it not?

Mr. MILLER. That is right.

Senator DONNELL. Therefore, if this taxation plan of paying for a vast health-insurance measure goes into effect, and if you want to get Dr. Jones, who lives over here at Seventeenth and S Streets, to prescribe for you and have it paid for out of the tax money, but Dr. Jones had not consented to enter into one of these agreements, you don't have any liberty under this bill to get him to render these services which have been paid for by taxation, do you?

Mr. MILLER. I will answer that by agreement with what the Senator has said.

Senator DONNELL. I want to call your attention further to page 20, if you will just turn to page 20 of the bill. Page 20 says, in referring to methods of payment for services that—

> Agreements for the furnishing of medical or dental services (other than specialist services) as benefits under this title shall provide for payment—

by four different methods, and I will just read the first two. I have no objection to reading the other two, but I don't think they are relevant—

> (1) on the basis of fees for services rendered as benefits, according to a fee schedule;
>
> (2) on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list.

Now I ask you, Mr. Miller, doesn't that contemplate as you read it, a per capita method, providing the doctors in the particular area involved decide on a per capita basis?

Mr. Miller. If that is adopted by the practitioners themselves by agreement with the State and local authorities, it does.

Senator Donnell. Well, Dr. Boas, I get from him—you know Dr. Boas, do you not?

Mr. Miller. I do not.

Senator Donnell. Have you ever heard of him, chairman of the Physicians Forum?

Mr. Miller. Yes, sir.

Senator Donnell. Well, I get just this language, and I assure you it is my understanding he has said this:

> Insurance guaranteeing complete medical coverage cannot be set up except at prohibitive costs if the fee-for-services principle is retained.

I take it that if we agree with Dr. Boas it would appear reasonable to assume that, at least in many areas of the country, this per capita basis will have to be adopted in order to make this scheme work. That is true, isn't it?

Mr. Miller. I don't know whether it will have to be adopted or not. Personally I prefer the fee-for-service plan if it can be adjusted, the right kind of plan.

Senator Donnell. This bill, however, permits this per capita basis if the doctors want to install it in any particular locality?

Mr. Miller. That is true; yes.

Senator Donnell. Now, Mr. Miller, suppose we say that in Sedalia, Mo., the doctors there decide that they want a per capita basis. That means, does it not, as you understand it, that a certain number of persons will be allotted to Dr. Jones, a certain number of persons will be allotted to Dr. Smith, and a certain number of persons to Dr. Williams. That is right, isn't it? That is the way that a per capita plan operates, isn't it?

Mr. Miller. Yes; but you can't read into this proposition that Dr. Jones and Dr. Smith and Dr. Williams will have to accept an undue number of special risks, an undue number of individuals. It lies within their capacity to refuse to do that.

Senator Donnell. I agree with you, and that leads right up to the point I am leading up to. There is this practitioners' list that is mentioned here, a list of, we will say, in the case of Dr. Jones, 200 patients; Dr. Smith, 200 patients; Dr. Williams, 200 patients. We will take that as an illustration.

Now, suppose, for instance, that it is determined that in Sedalia, Mo., the per capita basis is adopted, and it is decided that there are 200 patients to Dr. Jones, 200 to Dr. Smith, 200 to Dr. Williams. We will say that Dr. Jones is considered the best doctor in that country around, and there is an immediate rush down to the courthouse, to the Federal building, where they have the register of practitioners, the list; and instead of 200 people coming down, 400 come down to get on Dr. Jones' list, and the first 200 that get there get on his list. That is right, isn't it?

Mr. Miller. I would not think so.

Senator Donnell. How is that list made up, as you understand the actual operation?

Mr. Miller. I think it would have to be done by trial and error. I think that even if you have no list in Sedalia, some of these people are going to have to accept Dr. Williams rather than Dr. Jones, even if there is no system of this kind at all, because they are the medical purveyors in that community, and that is all there is.

I think there should be an equitable distribution of services, and I presume there can be provisions in emergencies, where surgery is required or in a childbearing case.

Senator DONNELL. But now let us follow through. We will take that phase up in a moment. Let us follow through the illustration I have used. Suppose that the practitioners' list for Dr. Jones is made up and consists of 200 names, all set down on the list, and then Mr. Miller, Mr. Watson B. Miller, who lives there, we will say, concludes that he wants to go to Dr. Jones, and there has been a tax paid in behalf of Mr. Miller, and he feels that he is entitled to his free choice of a physician, which is what you say in your statement, free choice of doctors—he is entitled to that, and he comes down and he says: "I am entitled under this bill, I am guaranteed the right, to get Dr. Jones."

Mr. MILLER. Dr. Jones won't have to take him. Dr. Jones can reject him.

Senator DONNELL. Dr. Jones can reject him. There are 300 people on his list, and Mr. Miller comes along, knowing that his taxes have been paid, and he wants Dr. Jones, and he is entitled, as I get from your statement, to free choice of doctors, and that choice is Dr. Jones, but there is nothing in this bill that permits you to select Dr. Jones and compel him to give you his services, is there?

Mr. MILLER. Under the capitation plan, that is right.

Senator DONNELL. And if you go to Dr. Jones and he has more patients than he wants, more than he can take care of, there is no law to compel him to take you?

Mr. MILLER. I agree with that.

Senator MURRAY. I beg pardon, but isn't there another system of elimination by just raising the fees?

Senator DONNELL. Yes; and I am glad you mentioned that, because I want to come to that in just a minute, about raising the fees.

However, Mr. Miller, if you go to Dr. Jones in Sedalia, and he looks you over and you look like you are a pretty sick man, and he wants to take you, and he says: "Well, my list—I really have as many patients as I can take care of, but I believe I can arrange to take Watson Miller. He is a good fellow, and he needs me right away"; and if he will take you, you can get his services. That is right; isn't it?

That is correct under a voluntary system, isn't it?

Mr. MILLER. That is right.

Senator DONNELL. But under the compulsory health insurance, when your taxes are paid, the only way you can get Dr. Jones then is to rely on the payment of taxes and get your free choice of doctors that is guaranteed here by the language of this bill? That is true, isn't it, under this bill?

Mr. MILLER. I don't know whether I think that would have to be true, whether it is authorized or not, but the law——

Senator DONNELL. Well, it is true under this bill, isn't it? You would agree to that?

Mr. MILLER. Yes.

Senator **Pepper**. Right on that point, that particular point, I don't think there is anything in the bill that fixes a mathematical limit to the number of patients, the per capita amount, that a doctor may serve.

Mr. **Miller**. It is done by negotiation within the State or community.

Senator **Pepper**. That is right. Then that is up to the judgment, up to the discretion, of the governing agency as to what the limit shall be. It is not even required that it shall be the same limit for all doctors. In other words, in the case put by the Senator from Missouri, if Dr. Jones wanted to attend Mr. Miller, and he could make any kind of showing to the governing board that he was able to do it, or if he wanted to reject some patient that he previously had on his capitation list and make a place for him, that would be possible, wouldn't it?

Senator **Donnell**. May I ask the Senator where there is in the bill any such provision?

Senator **Pepper**. I don't have it before me here at the moment, but there isn't any limit at all in there to the supervisory authority. But the Senator is assuming—I will ask him where he gets the authority in the bill to assume that there is a per capita basis limit.

Senator **Donnell**. I will call your attention to page 20, lines 7 to 9.

Senator **Pepper**. All that says is that benefits under this title shall provide for payment—

> (1) On the basis of fees for services rendered as benefits, according to a fee schedule.

That doesn't limit the number of patients. Then the next line:

> (2) On a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list.

That doesn't say how many can be put on the list.

Senator **Donnell**. No; I didn't say that the bill says how many are to be on the list, but there must be a limit somewhere. The Senator asked where I found in the bill anything about—I have forgotten the exact language—but limitation of the number on the list, but it seems to me that in lines 7, 8, and 9, where it says—

> on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list—

it seemed to me perfectly clear that that means a list containing a certain number. Somebody determines the number, it is true.

Senator **Pepper**. But the Senator is going on the complete assumption that somebody other than Dr. Jones would determine the number of people that he can care for on his list, and where does the Senator find anything in this law, or any authority for any public official to say to Dr. Jones in the case put by the Senator that he cannot attend Mr. Miller if he wants to attend Mr. Miller?

Senator **Donnell**. I may say to the Senator that I think it is perfectly clear from what I have read that this bill contemplates a practitioner's list with a certain number of individuals on the list. I am not saying whether it shall be the same in every community, but there is to be a list, and somebody determines the list; regulations will be set down here under the bill, and, as a matter of fact, as a practical illustration, in England I understand there have been lists fixed at 2,500 persons to a given doctor.

Senator PEPPER. That may be true in England, but we are talking about the specific bill here before us, and I understand that what the bill is saying in that subsection (2), to which the Senator refers, is just as any insurance company can send a certain number of people to a doctor with whom they have an agreement, or a hospital, that the doctor or the hospital would care for a certain number of patients; and then if they have an agreed schedule of fees, that they should pay as much for the number of people they care for that came in that category. But it was the Senator who was assuming that when the list got to 200 it was a hard and fast rule that there is an absolute prohibition against Dr. Jones attending Mr. Miller, if he wants to go there. I say that that is not justified.

Mr. MILLER. I see that section 219, beginning on page 22, gives us some additional information and flexibility. I think maybe section (c), at the bottom of page 23—

> In order to maintain high standards in the quality of medical or dental services furnished as benefits, a State agency may fix maximum limits for the State or for classes of health-service areas, upon the number of eligible individuals with respect to whom any person may undertake to furnish such services as benefits.

Senator PEPPER. And it goes on:

> The State agency may reduce such limits for a health-service area on the basis of the recommendations of the persons furnishing such service in the area:

—the recommendation of the doctor—

> Any such limits shall take account of professional needs and practices, shall provide suitable exceptions for emergency and temporary situations, and shall not exceed maximum limits fixed by regulations made by the Board after consultation with the Advisory Council, which regulations may provide for nationally uniform limits or for limits varied to take account of relevant factors.

Senator DONNELL. The Senator has very clearly read the language which obviously gives the Board—which, again, is under the direction and supervision of the Security Administrator—the right to prescribe maximum limits for these lists.

Senator PEPPER. I started off on the assumption that the Senator was right in assuming that there was a discretionary authority there to fix such limits, but it is very clear from reading this language that it is the outside limit that may be fixed by regulation, and I am assuming that these intelligent people are going to be advised by competent people, that they are going to take an outside limit which is a limit of reason and capacity. Now then, within that outside limit they are given discretion to determine how many people should be on this list. The Senator can put a hard case, like the one he put, that comes under emergency provisions, but the Senator surely would not want a doctor to profit here on the patient. Suppose the doctor should say "I will take 5,000" when 2,000 is the maximum number that any doctor can reasonably take care of; suppose he says, "I want to make more money, and I will take 5,000, I will take 10,000." Now, surely the Senator from Missouri would not allow a doctor to be paid from the common insurance fund for a number of people whom he could not possibly take care of, and it is a protection thrown around the people, it seems to me, and not undue interference on the part of the State authority.

Senator DONNELL. With reference to the point made by the distinguished Senator from Florida, who has given much thought and study to these problems over many years, I would like to make this statement, that the bill purports to provide free choice by the patient, as set forth in section 203, and was so understood by the person who prepared his statement in rough draft, and was relied on, obviously, by Mr. Miller in approving the rough draft, after changing it last Sunday, I believe he said, but I say that the provision in section 203, which he understood to provide free choice of doctors—and it says that in section 203—

> every individual eligible for personal health services available under this title may freely select a physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection—

with the proviso right after it, however, which does limit it, and my point is that although there is a glowing statement of the right of free choice of doctors, when you get right down to it this bill has exactly the same point that was emphasized repeatedly in the testimony on S. 1606, namely, that in a community in which the per capita plan shall be agreed upon, there shall be limits placed upon the number of persons, and that those limits shall not exceed certain maxima fixed by regulation made by the Board, which again is subject to the direction and control of the Federal Security Administrator, after consultation with the 17-member Advisory Council—16 of whom are appointed by the Federal Security Administrator—and that these limits, when once they are made, the doctors cannot exceed. Thus, if Mr. Jones had a limit of 200, and Mr. Watson Miller walks up there and wants to become a patient, leaving out for the moment the emergency situation to which the Senator referred—and I will refer to that in a moment—leaving that aside for the moment, if he just wants to be a steady patient of Dr. Jones right along, he cannot choose Dr. Jones.

Senator Pepper. But, Senator, the language of the act is intended to be synonymous with the competent capacity of the doctor. Now, the Senator surely would not suggest that a doctor today can attend more people than he can attend physically. There is a limit somewhere. He has got to have a little sleep. He can only attend a certain number of people. The Senator is imagining a case which is held to be beyond the capacity of the doctor. Today there are lots of people that do not have free choice of doctors, because, first, they cannot pay for it, secondly, because the doctor has got all he can do. A lot of times you call a doctor and he cannot come. If he has every patient he can possibly take care of, yes, you are then excluded because he can't take care of any more, but I don't think the Senator can substantiate that such is an effective denial of free choice of the people among you to select a doctor.

Senator Donnell. May I make the further point that today the doctor himself determines what is his capacity, and if Mr. Watson Miller goes to Dr. Jones in Sedalia, Mo., and Dr. Jones has 200 patients, the doctor himself can decide whether or not he is to take on 200 or 201; whereas, under the bill, Mr. Watson Miller or his successor in Washington, D. C., has it within his power to say how many patients Dr. Jones may take. I think that is perfectly clear.

Mr. Miller. But you have to read that with the context, Senator Donnell.

Senator Donnell. Is there anything in the context that would disturb that conclusion?

Mr. MILLER. I think so. If the Senator will look at page 24, under the heading "Professional rights and responsibilities," termination of agreements, for example, in (a) and in (b):

> Every physician, dentist, or nurse agreeing to render services as benefits under this title shall be free to practice his profession in the locality of his own choosing, consistent with the requirements of the laws of the States.

I take it that would apply, irrespective of what they call a "panel" in England, and what you might call a "list" in this country. And in connection with the latter part of (c) under 219, which takes cognizance of relevant factors—emergencies, without doubt, among other things such as temporary situations—that matter takes care of itself. I don't think it is perfect, and I don't think, as I said this morning, that this law can spring full-fledged at the moment it is signed, in maximum usefulness and effectiveness, but I say it is a start.

Senator DONNELL. Referring to Mr. Miller's comment, reading from section 220, I don't think that deserves the conclusion that you suggest, because, while certain provisions are set forth therein with respect to professional rights and responsibilities, obviously the statute would be read in the light of well-established statutory rules of interpretation, so as to make effective every provision of the statute, and while it is true that the physician may be—

> free to the extent consistent with applicable State law and customary professional ethics to accept or reject as a patient any individual requesting his services—

he could keep him off the panel under that language, I take it, yet when the Board down here in Washington, under the supervision and direction of one man, fixes a panel, those limits—and I quote again from page 24—

> shall not exceed maximum limits fixed by regulations made by the Board, after consultation with the Advisory Council, which regulations may provide for a nationally uniform limit or for a limit varied to take account of relevant factors.

The very fact that in that sentence the only exception that is provided therein is this matter of emergency, to which I stated I would refer in a moment—emergency, a temporary situation—quoting lines 5 and 6—

> shall provide suitable exceptions for emergency and temporary situations—

indicating, obviously, that the Board, subject to the direction and supervision of the Federal Security Administrator, may make limits, maximum limits not to be exceeded.

Mr. MILLER. That is what you want to serve, is it, the emergency?

Senator DONNELL. Yes.

Mr. MILLER. Obviously, you and I would be running a job in a very captious manner if we did not make provision for Dr. Jones, if Dr. Jones is the only man in Sedalia, Mo., who could do laparotomy, and for his payment and for treatment by Dr. Jones. I don't think we have an insuperable situation here.

Senator SMITH. Just a minute there. I want to get the judgment of my colleague here. It is 10 minutes of 1. Another subcommittee meets at 1:30 this afternoon, that Senator Donnell and I both have to attend. When we recess now we must recess, I think, until 2:30. Dr. Parran is the next witness, and I asked him if he could come at 2:30 and he told me he could, so the question arises, Senator Donnell, Senator Murray, and Senator Pepper, can you estimate how much longer you would like to question Mr. Miller, and whether I should tell Dr. Parran we will not get to him today, and possibly put some of these witnesses over till tomorrow?

Senator Donnell. In regard to Mr. Miller, I will say that in my judgment I will be finished with my interrogation of him in not to exceed 10 minutes.

Mr. Miller, I would like to ask you which of the following agencies are under the Federal Security Agency of which you are the head: United States Public Health Service?

Mr. Miller. Under my supervision.

Senator Donnell. Children's Bureau?

Mr. Miller. Under my supervision.

Senator Donnell. Office of Education?

Mr. Miller. Under my supervision.

Senator Donnell. United States Employment Service?

Mr. Miller. Not under my supervision.

Senator Donnell. That is temporarily in the Labor Department?

Mr. Miller. Department of Labor—I heard the able Senator argue that point on the floor of the Senate.

Senator Donnell. It is referred to your Department under the provisions of the War Powers Act?

Mr. Miller. Yes; I believe so.

Senator Donnell. The Department of Agriculture, of course, is not under you. Your research and statistics, Social Security Board. That is in your Department?

Mr. Miller. Yes, sir.

Senator Donnell. That is the Bureau of which Mr. Isidore Falk is the head?

Mr. Miller. Yes, sir.

Senator Donnell. Did you appear as a witness before the Committee on Expenditures in the Executive Departments in the House of Representatives recently?

Mr. Miller. No.

Senator Donnell. Have you seen the report of that committee?

Mr. Miller. I saw it for the first time yesterday afternoon.

Senator Donnell. I am going to offer at this time——

Mr. Miller. I should like to say, to make myself perfectly clear, I did confer with Representative Harness of Indiana, in company with Mr. William Mitchell, but it was only in the sense of proffering him all of the facilities we had in the way of giving information or records, and to express the hope that the proceeding would be not an ex parte one, and that I would have an opportunity to enter such material as seemed pertinent. That did not come about. I am finding no fault, of course.

Senator Donnell. Mr. Isidore Falk's administrative assistant is Miss Margaret Klem, is she not?

Mr. Miller. I think so.

Senator Donnell. Do you know as a fact that she was a witness before the Committee on Expenditures in the Executive Departments in the House?

Mr. Miller. I don't know it as a fact, unless it is so set out in the report.

Senator DONNELL. It is set out in the report, and I have a copy of her testimony here. She was a witness on June 18, and she is Chief of the Medical Economics section of Mr. Falk's division?

Mr. MILLER. Yes, sir.

Senator DONNELL. She was one of the group of Federal employees that charted, arranged and conducted the Jamestown, N. Dak., Health Workshop?

Mr. MILLER. That is not within my knowledge at the moment. It is possible.

Senator DONNELL. There was testimony the other day here by a lady from North Dakota, Mrs. Evanson, who appeared here for a farm organization, that she herself had been present at Jamestown, and that there were some 20 representatives of Federal departments here at that so-called Jamestown Health Workshop, and it was that Health Workshop at which some expression of opposition to S. 545, I believe, was drawn up, and possible some commendatory expressions with respect to S. 1320.

Mr. MILLER. That I do not know.

Senator DONNELL. I call your attention to the fact that in this report of this Committee on Expenditures in the Executive Departments, which was filed on June 2, 1947, and in Report No. 786 of the Eightieth Congress, first session, appears this language:

> Mr. Isidore Falk is Director of the Division of Research and Statistics in the Social Security Board.

That is page 5—

> His principal assistant, Miss Margaret Klem, was a witness before your committee on June 18. Miss Klem was identified as Chief of the Medical and Economics Section of Mr. Falk's Division, that she is one of the group of Federal employees who charted, arranged and conducted the Jamestown Health Workshop. The testimony also discloses that she helped draft the Wagner-Murray-Dingell bill.

I would like the record to show at this point, if I may, Mr. Chairman, a few of these questions and answers here from the transcript of the hearing, page 265 of the typewritten testimony of Miss Klem:

> Miss KLEM. I wonder if I might make one statement about the statement made this morning?
>
> The CHAIRMAN. By whom?
>
> Miss KLEM. It was by Mr. Engebretson. If I remember correctly, he said that I had influenced the drafting of the Wagner-Murray-Dingell bill, or something of that sort. I did not know whether I should let it go into the record like that, because although we do give information and help when we are requested, I do not believe that I could say that I influenced the drafting of that bill.
>
> The CHAIRMAN. Did you have anything to do with the drafting of the bill?
>
> Miss KLEM. Yes; I attended meetings when the bill was discussed.
>
> The CHAIRMAN. When provisions were being put together in the bill?
>
> Miss KLEM. That is right.

I offer that in the record. Is there more to come? Then I would like to offer in the record—I would like to ask you, Mr. Miller, first, did you know anything about Miss Klem attending these meetings at which the Wagner-Murray-Dingell bill was drafted?

Mr. MILLER. I not only knew nothing about her attending, but I did not know of her attending any conference where the bill was drafted. It could be, however.

Senator Pepper. Senator, did you understand that the conference referred to was an interdepartmental conference or does it say? I got the impression that it might have been a conference within the department.

Senator Donnell. I think, Senator, this is the workshop in St. Paul. I find that at page 264 she refers to the St. Paul workshop.

Senator Pepper. But I am talking about the drafting of the bill.

Senator Donnell. I don't know that that was an interdepartmental conference. I think it was a workshop conference.

Senator Pepper. But the bill was not drafted in a workshop by any means. I just wanted to see if there was anything that excluded the idea that when the lady refers to sitting in in consultation, it might have been in consultation with other departments.

Senator Donnell. I see your point. I think you are quite correct. I think the workshops were the workshops at which were considered these various matters of legislation, and at which expressions of opinion were drawn up, and in the case of the Jamestown workshop that was attended by many Federal employees, and I observe at page 264 of her testimony, referring to the St. Paul workshop, the question is:

> You met there with representatives of these organizations, CIO, A. F. of L., and Farmers Union?
>
> Miss Klem. And the railroad brotherhoods.

and that she participated in the forum panels, and so forth, that were held at those workshops, as a consultant. That appears at pages 264 and 265. Where those meetings took place at which the drafting of the bill occurred, I am unable to state, but the inference I draw is that it was not in those workshops.

Senator Pepper. Now, the Senator does not suggest that the participants in those workshops, the railroad brotherhoods, the A. F. of L., the CIO, were un-American, or were citizens other than citizens of the United States?

Senator Donnell. No; I have no such inference to draw, but I am presenting the thought that governmental employees in Mr. Miller's department, certainly Miss Klem, were participating in these workshops, and the purpose of the point that I am presenting now will be noted by citing, in addition to the full report which I now ask—it is only seven pages—may be set forth in the record—signed by the chairman, Mr. Harness, James W. Wadsworth, Henry J. Latham, Carter Manasco, and J. Frank Wilson; a report of Mr. Hoffman from the Committee on Expenditures in Executive Departments, authorized to investigate publicity and propaganda of Federal officials in the formation and operation of health workshops. I offer this entire document.

Senator Smith. You say that it is a report of the House committee?

Senator Donnell. The report of the House Committee on Expenditures in the Executive Departments.

Senator Pepper. Before the Chair rules on that, may I be permitted to make an observation?

Senator Donnell. Certainly.

Senator Pepper. I will ask the clerk to bring me a copy of the report, or will the Senator lend me his, or do you have a copy there? [The clerk handed the report to Senator Pepper.]

Mr. Chairman, I don't know any rules of evidence, of course, that govern what goes into the record in a committee hearing of this character that would apply if it were a court proceeding of some sort, but I do submit that there are certain fundamentals in our whole American concept of inquiry—I think Daniel Webster defined inquiry as defying due process of law, as a procedure of condemnation before the court has rendered judgment. Now, the House of Representatives, I respectfully submit, has not observed this fundamental American concept of due process of law or, in terms of lay language, fairness.

While Miss Klem may have been invited as a witness, Mr. Miller, who is the head of the Federal Security Agency and the man legally responsible for the administration of most of these bureaus which are mentioned here, was not permitted to be heard before he was condemned, and his Agency condemned, for improper action, although he proffered, according to his testimony, his testimony and his services to the committee, and in making the inquiry, so far as I know, so far as the record has disclosed here this morning, none of the other people that are mentioned and condemned in this report were heard by the House committee when it formed the basis of this report.

Mr. Miller. May I make an inquiry of one of my associates? I want to be sure that the statement of the Senator from Florida is accurate. Was I called before the committee myself?

Mr. Harry N. Rosenfield. Not to my knowledge.

Mr. Miller. Do you recall before what committee I was called when I was out on the west coast?

Mr. William Mitchell. I can answer that. You were called before the over-all Committee on Executive Expenditures when they were considering the President's reorganization plan.

Mr. Miller. Then my statement that I did not appear would be supported by the proposition that I was not called.

Senator Donnell. May I ask, Mr. Miller, did you discuss any of these matters with Mr. Harness, the chairman of this subcommittee, Forest A. Harness?

Mr. Miller. I went there for the purpose of finding out the nature of the inquiry, in order that I could make available, without any reservation whatever, any records or any information that lies within our power, in addition to the written record. And I expressed the hope at that time that if there were to be further proceedings, we would have an opportunity to be heard, and some of us were, I have no doubt.

There was one further thing discussed with Mr. Harness and Mr. Mitchell and myself, and that was the proposition that Mr. Harness has stated on the floor of the House, that we proposed sending Mr. Jacob Fisher of our staff to New Zealand for the purpose of giving us a first-hand report on the operation of their general social-security system, which did include some services in the health field.

I will add that in view of our deep respect for the American Congress and its Members, and apprehending that there might be further inquiry, we deferred the proposed visit of Mr. Fisher to New Zealand until some time that the Congress would consider more appropriate.

Senator Pepper. If the Senator will allow me to proceed with my objection—in the second place, Mr. Chairman, I don't know of anything that distinguishes activities of these agencies from the general activities of the agencies of the United States Government. I know I have been to many public meetings, agricultural meetings, livestock meetings, and others, where representatives of the Government whose duties had to do with the purposes of that meeting were represented.

In the next place, on page 6 of this report we see the attitude of this committee toward the Department of Justice of the United States and toward the Supreme Court of the United States. I will read two paragraphs:

> In this connection, your committee recalls that it was the activities of the Group Health Association of Washington, D. C., which led to the filing, in 1937, of the antitrust proceeding against the Medical Society of the District of Columbia and the American Medical Association under the Sherman Antitrust Act.
>
> This legal action by the Department of Justice was carried to the Supreme Court of the United States on the basis of the original complaint and accusations of Group Health Association of Washington, D. C., serving effectively to intimidate and restrain the activities of the American Medical Association in resisting the Federal propaganda.

Now, Mr. Chairman, it is a serious thing for a committee of the United States Congress to condemn a group of citizens for calling attention to the violation of a Congressional enactment, and then condemn them for initiating a prosecution which resulted in a conviction in the courts of the country, and affirmance of that conviction by the Supreme Court of the United States.

In the last instance, on page 7, here is a concluding paragraph which shows the nature of this inqury, and effectively establishes that it does not meet, it seems to me, the standards that should be applied to documents and inquiries of this sort. Here is a conclusion arrived at, although these people never had a chance to be heard. I read from page 7, the concluding paragraph—this is talking about the health program that we Senators have introduced here as colleagues of these gentlemen in the elective body of the people of the United States—

> Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism hold this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard.

Now, that is a base calumny and a damnable lie, and I speak for myself as one citizen of the United States, and any Member of Congress or of that committee that imputes communistic motives to the author of this bill, they are damnable liars, and some of us here have heard it till we are getting a little tired of it, and yet they come along, and it is part of the same thing that we heard a little about awhile ago, when Mrs. Shearon, who was originally attached to the staff of this committee, and who sits in this committee today as the adviser of the Senator from Missouri, although her services with this committee have been terminated by the committee, has published a pamphlet entitled "Blue Print for the Nationalization of Medicine," in which there appears a chart headed "Administration plan for nationalization of medicine. Spheres of influence and interlocking directorates, collaborationists, fellow travelers, appeasers, satellites, and gullible accepters." Then she has got this chart which includes the President of the United States, the Washington Post, and over here Members of Congress, Representative Biemiller, Senators Wagner, Murray, and Pepper, Congressional committees, House Ways and Means Committee, Social Security technical staff included John J. Corson; Senate Finance Committee, Senate Education and Labor Committee, Senators Murray and Pepper, Democratic National Committee. Then Wilbur J. Cohen, adviser to Altmeyer, assistant to Falk; Margaret C. Klem, liaison with SSB field staff; Committee on Economic Security, American Association for Labor Legislation; ILO Special Committee on Seafarers' Insurance.

Then over here is Michael M. Davis, lobbyist, organizer, consultant to Falk; Barkev S. Sanders, health and disability studies chief; American Public Welfare Association; American Public Health Association.

Then up here under "Lobbying groups" are listed the Physicians Forum; Committee for the Nation's Health; Committee of Physicians for the Improvement of Medical Care; Committee on Research in Medical Economics; Federal Security Agency, Watson B. Miller, Administrator; United States Public Health Service, naming Dr. Parran, Dr. Mountin, George St. J. Perrott, W. P. Dearing, Louis R. Reed; United States Department of Agriculture; United States Department of Labor. Then under "Committees on Executive Agencies": Committee on Adequacy Studies, Subcommittee on Medical Care, United States Public Health Service Legislative Committee, and so on.

So I submit, Mr. Chairman, that while there is no rule that applies to the admission of evidence here, here is an ex parte statement that is made by this committee of the House, and purports to have an authenticity which it does not possess, and I think the whole character of it and the manner in which it was put together indicates that it is not deserving of being included in the records of this committee. If this committee wishes to ascertain anything it should make its own inquiry, as it is doing now. These people are here before us. This man is head of the Agency, and it would be better for us to be governed by our own inquiry—at least when these people would have an opportunity to present themselves. I respectfully object to the submission of the report.

Senator SMITH. The objection will be noted, of course, as the Senator requests, but I want to call attention to the fact that this committee is not sitting in judgment on anybody. The committee is not trying anybody. This committee is endeavoring to find out ways and means to pass legislation to meet an important objective, and I can see no objection to anything that is brought before the committee being used by the committee itself, when they are considering the framing of legislation, and I am very happy to note—I am not happy, but I am sorry—that the Senator from Florida feels offended by the offering of this document, but the Senator's comments will be included also in the record, and if Senator Murray wishes to make any comments they will be included in the record, so we will have the views of everyone when we come to consider the legislation. I think that is the proper way to handle it. I dislike to rule some evidence out and admit other evidence. There is a difference of opinion, of course. Many people feel that propaganda has been carried on both ways in regard to this legislation, and as chairman of the subcommittee I am trying my best to separate the so-called chaff from the wheat and see if we can get at the facts that will get the bill that we all desire.

(H. Rept. No. 786, 80th Cong., 1st sess., follows:)

FIRST INTERMEDIATE REPORT OF THE SUBCOMMITTEE OF THE COMMITTEE ON EXPENDITURES IN THE EXECUTIVE DEPARTMENTS AUTHORIZED TO INVESTIGATE PUBLICITY AND PROPAGANDA OF FEDERAL OFFICIALS IN FORMATION AND OPERATION OF HEALTH WORKSHOPS

FOREWORD

The committee, after full consideration of the report as submitted by the subcommittee, upon motion duly made and seconded, unanimously approved and adopted the report as the report of the full Committee on Expenditures in the Executive Departments. The chairman was directed to transmit a copy of the report to the Speaker of the House of Representatives.

Your committee reports to the House that, on the basis of hearings held on May 28 and June 18, 1947, it finds that at least six agencies in the executive branch are using Government funds in an improper manner for propaganda activities supporting compulsory national health insurance, or what certain witnesses and authors of propaganda refer to as socialized medicine, in the United States.

This report summarizes our hearings on this phase of the inquiry to date and presents the conclusions arrived at, following careful evaluation of the testimony and documentary evidence presented by, and relating to, the several Federal agencies involved.

The departments, bureaus, and agencies known to have participated in this campaign are:

1. The United States Public Health Service;
2. The Children's Bureau;
3. The Office of Education;
4. The United States Employment Service;
5. The Department of Agriculture; and
6. Bureau of Research and Statistics, Social Security Board.

Your committee finds that the use of Federal funds for the purpose of influencing legislation before Congress is unlawful under section 201, title 18, of the United States Code. We have, therefore, brought these matters to the attention of the Department of Justice, with a request that the Attorney General at once initiate proceedings to stop this unauthorized and illegal expenditure of public moneys. A copy of the chairman's letter to the Attorney General is made a part of this interim report (exhibit 1).[1]

Our exhibit 2,[2] in this report, is a chart prepared by the committee staff, showing the number of Federal agencies and the number of Federal pay-roll personnel participating in the so-called health workshops arranged throughout the country during the last 2 years, to mobilize pressure groups in behalf of a national program for what certain witnesses and authors of propaganda refer to as socialized medicine.

The first meeting in furtherance of these health workshops was held in Washington, D. C., on November 2, 1945. At that meeting only 10 persons were present, all of them full-time employees of the Federal Government. George Perrott, of the United States Public Health Service, presided as chairman of the meeting. The Federal agencies represented in this meeting—and the representatives of these agencies were the only persons present—were United States Public Health Service, Department of Agriculture, and the Federal Security Agency.

The latest figures available from the Budget Bureau show that for the fiscal year 1946 total expenditures in the executive branch for publicity and propaganda activities were $75,000,000. During that fiscal year 45,000 Federal employees were engaged, full or part time, in such activities. The most recent prior compilation by the Budget Bureau covering the fiscal year 1941 showed total publicity expenditures amounting to $27,770,000. An increase of approximately 300 percent in Federal expenditures for publicity and propaganda in a period of 5 years is deemed by your committee to be a proper subject for inquiry by the Congress.

It will be the purpose of your committee, in future interim reports, to examine this expenditure in detail by departments and agencies, with particular refer-ance to illuminating those activities which are directed primarily to influencing the decisions of Congress on pending legislation.

---

[1] See appendix, p. 7.

[2] See appendix, p. 8.

Our first report deals exclusively with activities calculated to build up an artificial, federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance referred to by witnesses and publications as the Murray-Wagner-Dingell bill.

The extraordinary executive pressure exerted upon the staff of the United States Public Health Service to further the campaign for what certain witnesses and authors of propaganda refer to as socialized medicine is indicated by a letter sent under date of December 10, 1945, by Thomas Parran, Surgeon General of the United States Public Health Service, to all field men and staff operatives throughout the country. This letter referred to the message sent to Congress on November 19, 1945, by President Truman, urging enactment of a national health program. The Surgeon General's letter referred to the President's message as "a subject of the highest importance to every citizen." His letter continues (transcript of hearing, May 28, 1947, p. 88):

"The appropriate executive agencies of the Government have been specifically instructed by the President to assist in carrying out this legislative program as presented to Congress on September 6, 1945."

The Surgeon General then listed the several health bills pending before Congress, continuing:

"Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service."

Pursuant to this policy, the Public Health Service launched its national program of health workshops.

Following the Washington conference of November 2, 1945, a broader planning conference was arranged at the University of Chicago, November 26–27, 1945. At this meeting 20 persons were present, 9 of whom were full-time employees of the Federal Government. The 11 non-Government persons in this meeting were representatives of the CIO, A. F. of L., and the Farmers Union.

Next the planning committee met in Washington, D. C., on December 10, 1945, to evaluate the Chicago meeting and plan for the health workshops. The first health workshop was held in St. Paul, Minn., February 6–10, 1946, with 80 persons participating, 15 of whom were Government employees, representing 7 different agencies in the Federal establishment.

The second health workshop was held in Jamestown, N. Dak., September 27–30, 1946, with 98 persons participating, 18 of whom were Federal employees, representing 7 Federal agencies. The chairman of this meeting was Dr. Mayhew Derryberry, Ph. D., of the United States Public Health Service. Apart from Federal personnel, there were no doctors of medicine in attendance at this meeting as delegates. The testimony before your committee indicates that no registered doctor of medicine was invited to participate.

All the evidence before your committee indicates that these health workshops were planned, conducted, and largely financed with Federal funds, by a key group on the Government pay roll, who used the workshop method of discussion subtly to generate public sentiment in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine. It is evident from the record that most of the planning was done by the Federal officials in Washington prior to each workshop conference and that each meeting was devoted to their own purposes—that of organizing pressure groups to agitate for compulsory health insurance as then pending in Congress.

In preparation for the Jamestown Health Workshop, the Public Health Service distributed in advance to all invited delegates a packet of pamphlets published by the CIO, AFL, the Physicians' Forum (a propaganda agency for the Wagner-Murray-Dingell bill), and the Government bureaus, in support of what certain witnesses and authors of propaganda refer to as socialized medicine. These packets were mailed to the delegates in advance of the conference, at Federal expense. They urged that letters be written to Senators and Representatives advocating immediate action on the Wagner-Murray-Dingell bill.

After the propanganda packets had been delivered, well in advance to the invited delegates, the Jamestown Health Workshop assembled on September 27.

Your committee received a detailed account of this health workshop from Mr. E. F. Engebretson, executive secretary of the North Dakota State Medical Association, who attended as an uninvited observer. On June 18, 1947, Mr. Engebretson testified:

"The meeting began on Friday, September 27. Friday was spent in its entirety in a so-called training program. The sponsoring organizations had invited various Federal and State officials to attend the conference as so-called consultants. Twenty-one of these consultants were in attendance, of which 19 were Federal employees and 2 were employees of the State of North Dakota.

"The training session the first day was not open to the general membership of the Farmers Union or other groups sponsoring the program. Rather, a hand-picked group of leaders from the various local societies were brought in for the purpose of being trained in workshop procedure. This training program was handled entirely by the employees of the Federal Government. In charge of the program in a general way was Dr. Mayhew Derryberry, Chief of the Office of Health Education, United States Public Health Service. In charge of the training instructions was a Dr. Hubert Stanley Coffey, Chief of Training, Federal Security Agency. The hand-picked group from the local societies were designated as delegates, and in training them they were seated around a conference table with the 21 consultants lined up behind them."

After the training program the indoctrinated delegates were given 30-minute tests to measure their leadership ability by setting forth the immediate health needs of North Dakota. At this point Witness Engebretson testified:

"It was very interesting to note that when left to themselves the delegates seemed unable to think of any particular health problems in the State."

Your committee then obtained from the Federal Security Agency a full copy of the instruction sheets used by the training officers at these health workshops. Among the topics listed are:

Techniques for the organization of citizen groups.
Formation of pressure groups.
Methods of bringing about group action.

Testimony demonstrating the efficacy of this indoctrination of delegates by the Federal officials was found in the formal summary of the Jamestown Workshop, as presented by the United States Public Health Service.

One section of the "action program," approved by the conference, urged "that congressional candidates and incumbents be polled by the committee, on their stand on the national health program, and that their opinions be sent to the State organizations for publication."

In the opinion of your committee, this recital presents the complete picture of Government propaganda in action. The Federal employees arrange the meeting, invite the delegates, train the delegates, preside at the meetings, and then frame the formal summary of resolutions and actions.

And all of this is paid for with public moneys never authorized or approved by Congress for these or any like purposes.

Testimony before the committee indicates also that the staff and resources of the Bureau of Research Statistics in the Social Security Board were devoted freely, from time to time, to the preparation of pamphlets and propaganda literature for the CIO, the AFL, and the Physicians' Forum. Much of this material prepared for the CIO and other groups, by the Social Security Board at Government expense, supported what certain witnesses and authors of propaganda refer to as socialized medicine in every approach and dismissed contemptuously all arguments controverting the fixed position of the Social Security Board (transcript of hearing, June 18, 1947, p. 170).

Your committee concludes from the testimony that most, if not all, of this literature, as distributed by the CIO, the AFL, the Farmers' Union, and the Physicians' Forum originates in, and emanates from, the Bureau of Research and Statistics in the Social Security Board. Mr. Isadore Falk is Director of the Division of Research and Statistics in the Social Security Board. His principal assistant, Miss Margaret Klem, was a witness before your committee on June 18. Miss Klem was identified as Chief of the Medical Economics Section of Mr. Falk's Division. She was one of the group of Federal employees who charted, arranged, and concluded the Jamestown Health Workship. The testimony discloses also that she helped draft the Wagner-Murray-Dingell bill.

At a later date, your committee will submit a separate detailed report on the activities of the Social Security Board during the last 10 years in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine.

Other evidence before the committee reveals that the Bureau of Research Statistics of the Social Security Board also prepared pamphlets and propaganda material to be distributed under the imprint of the CIO. Similar pamphlets were prepared in the same office for distribution as Government literature through the Department of Agriculture's Interbureau Committee on Postwar Programs. All this material, as presented in our hearings, is similar in tone, content, and objective. It all originates in one spot, in the Social Security Board. It is all paid for, save the actual printing, by a process which your committee deems an improper use of Federal appropriations.

Samples of all these pamphlets and propaganda leaflets are available in your committee's files for examination by the public. Photostatic copies of some of them have been transmitted to the Attorney General, with our request for action in defense of the American taxpayers, who are paying the bill.

The spirit and purpose which dominates the officials of the United States Public Health Service in their campaign to high-pressure this legislation through Congress is reflected faithfully in the testimony of Dr. Herman Hilleboe, Assistant Surgeon General, who appeared before the committee on May 28, 1947. He was asked by our committee chairman if the literature prepared by the Federal agencies offered all sides of the discussion or was limited merely to supporting material to carry out the President's order. To this question, Dr. Hilleboe answered: "We would naturally give emphasis to that, because that is why we are in government. Otherwise, we should get out of government."

The same attitude of intolerance toward honest discussion or debate of the issue was indicated in the testimony of Mr. Harry J. Becker, health consultant in the United States Children's Bureau, Federal Security Agency.

Questioned as to the number of speeches he had made throughout the country in advocacy of the subject, the witness recalled several such appearances. Committee counsel, Frank T. Bow, pressed the inquiry (transcript of hearings, June 18, 1947, p. 228):

"Mr. Bow. Did you give both sides of the question of compulsory national health insurance when you gave your discussions?

"Mr. Becker. I don't know what you mean by 'both sides.'"

The Children's Bureau, Federal Security Agency, was represented in the health workshops movement by Mr. Harry J. Becker, a full-time employee of the Federal Security Agency, in the capacity of health consultant. Mr. Becker, while engaged in his Federal position, also was one of the principal organizers of the Group Health Association of Washington, D. C., of which he later became president. He is also vice president of Cooperative Health Federation of America, which he helped organize in meetings at Two Harbors, Minn., and Columbus, Ohio, while on the full-time pay roll of the Children's Bureau.

In this connection, your committee recalls that it was the activities of the Group Health Association of Washington, D. C., which led to the filing, in 1937, of the antitrust proceeding against the Medical Society of the District of Columbia and the American Medical Association under the Sherman Antitrust Act.

This legal action by the Department of Justice was carried to the Supreme Court of the United States on the basis of the original complaint and accusations of Group Health Association of Washington, D. C., serving effectively to intimidate and restrain the activities of the American Medical Association in resisting the Federal propaganda.

Mr. Becker was a witness before your committee on June 18. His testimony delineates in some detail the historical development of the movement within the Federal Government to set up, at Federal expense, a Nation-wide campaign in support of pending legislation. Your committee invites particular attention to the testimony and cross-examination of Mr. Becker, because we feel that the devices and arrangements of Federal employment in this instance provide a typical example of how funds appropriated by Congress for the legitimate expenses of Federal agencies are diverted within the bureaus to full-time propaganda for what certain witnesses and authors of propaganda refer to as socialized medicine.

Not only are men and women paid substantial salaries in their Federal positions for their full-time activities in other fields, but in many instances traveling expenses and incidental costs of these pressure-group meetings are paid out of funds of the same Federal agencies.

Your committee has, for example, a report from the General Accounting Office, showing that various Federal agencies paid out a total of $1,950 in traveling expenses of Federal employees to and from the Jamestown Health Workshop. This conference took 18 Federal officials away from their desks for a total of 126 man-days.

Another report from the General Accounting Office shows that the Federal Government paid almost $5,000 in traveling expenses of Federal employees for the series of five health workshop conferences and planning meetings held throughout the country before our investigation began.

Certain documentary evidence also has come to the attention of your committee, that the Bureau of Research and Statistics in the Social Security Board also maintains close contact with movements for compulsory health insurance in other countries.

Under date of May 14, 1947, Mr. Isadore Falk, Director of the Bureau of Research and Statistics, sent a memorandum to the Acting Commissioner for Social Security, urging that one Jacob Fisher, a member of Mr. Falk's staff, be sent to New Zealand at Government expense, to study compulsory health-insurance programs and activities in that nation.

We find that this same Jacob Fisher has been documented by the House Committee on Un-American Activities for almost uninterrupted association, since 1939, with various Communist-front and fellow-traveler organizations in the United States. At various times, according to his record, Jacob Fisher has been identified with seven different groups or organizations avowedly sponsoring the Moscow party line in the United States. He has published at least one report on health insurance in New Zealand, in the Social Security Bulletin—a report which has been criticized by some reputable medical authorities as extremely biased.

In a later interim report on the propaganda activities within the Social Security Board, we shall present to the Congress the detailed record of Jacob Fisher's activities, as certified to us by the Committee on Un-American Activities, together with additional material bearing upon organized Communist agitation for what certain witnesses and authors of propaganda refer to as socalized medicine, through such agencies as the Southern Conference for Human Welfare.

Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow-travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard.

Approved:

Forest A. Harness, *Chairman.*
James W. Wadsworth.
Henry J. Latham.
Carter Manasco.
J. Frank Wilson.

Exhibit 1

Congress of the United States.
House of Representatives,
Subcommittee on Publicity and Propaganda of the
Committee on Expenditures in the Executive Departments,
Washington, D. C., June 30, 1947.

Hon. Tom C. Clark,
Attorney General of the United States,
Department of Justice, Washington, D. C.

Sir: There is transmitted to you, herewith, a copy of the Interim Report of the Subcommittee on Publicity and Propaganda of the Committee on Expenditures in the Executive Departments, for your consideration and appropriate action.

It is the opinion of the subcommittee, from the evidence considered by it at public hearings, that there have been violations of section 201 of title 18 of the United States Code, by employees of the departments and agencies specifically mentioned in the report. It is suggested and recommended that action be taken by the Attorney General of the United States to prosecute these violations and to prevent further disregard by Federal employees and agencies of the law cited.

The hearings and evidence adduced by the subcommittee are available and will be supplied to the Department of Justice upon request.

I have the honor to remain,
Yours very truly,

Forest A. Harness, *Chairman.*

EXHIBIT 2.—*Fedeal employee participation in health-workshop program*

	Washington, D. C., Nov. 2, 1945	Chicago, Ill., Nov. 26–27, 1945	Washington, D. C., Dec. 10, 1945	Minneapolis, Minn., Dec. 28–29, 1945	Minneapolis, Minn., Jan. 9, 1946	St. Paul, Minn., Feb. 6–10, 1946	Washington, D. C., May 13, 1946	Fargo, N. Dak., July 13, 1946	Great Falls, Mont., July 15, 1946	Denver, Colo., July 17, 1946	Jamestown, N. Dak. Sept. 27–30, 1946	Washington, D. C., Oct. 29, 1946	Aberdeen, S. Dak., Nov. 22, 1946
*Kenneth Pohlmann, Agriculture Department	X	Ch.	X	----	----	X	X	X	X	----	X	X	----
*Dr. Mayhew Derryberry, U. S. Public Health Service	X	X	----	----	----	X	Ch.	X	X	----	Ch.	Ch.	----
*Harry Becker, Federal Security Agency	X	X	X	----	----	X	----	----	----	----	X	----	----
*Eleanor Finger, Federal Security Agency	X	----	----	----	----	----	X	X	X	X	X	X	----
*C. L. Williams, U. S. Public Health Service	X	----	----	----	----	----	X	----	----	----	----	----	----
*George Perrott, U. S. Public Health Service	Ch.	----	----	----	----	----	----	----	----	----	----	----	----
*Dr. W. P. Dearing, U. S. Public Health Service	X	X	Ch.	----	----	X	----	----	----	----	----	----	----
*Dr. George H. Hunt, U. S. Public Health Service	X	----	----	----	----	----	----	----	----	----	----	----	----
*Frank Stafford, Federal Security Agency	X	X	X	----	----	X	X	----	----	----	----	----	----
*Barkev Sanders, Federal Security Agency	X	----	----	----	----	----	----	----	----	----	----	----	----
*Margaret Klem, Federal Security Agency	----	X	X	----	----	X	----	----	----	----	X	X	----
*Helen Manley, Federal Security Agency	----	----	----	----	----	----	----	----	----	----	X	X	----
*Dr. Mark Zeigler, Agriculture Department	----	----	----	----	----	----	X	----	----	----	X	X	----
*Elliott Pennell, U. S. Public Health Service	----	----	----	----	----	----	----	----	----	----	----	X	----
*Miss Thorne, Federal Security Agency	----	----	----	----	----	----	----	----	----	----	----	X	----
*Ralph Nanderworker, Federal Security Agency, housing	----	----	----	----	----	----	X	----	----	----	X	X	----
*Dr. Hubert Coffey, Federal Security Agency	----	----	----	----	----	----	----	----	----	----	X	----	----
Evelyn Rahm, U. S. Public Health Service	----	----	----	----	----	----	----	----	----	----	X	----	----
Dr. Arthur B. Price, U. S. Public Health Service	----	----	----	----	----	----	----	----	----	----	X	----	----
Edith Foster, Federal Security Agency	----	----	----	----	----	----	----	----	----	----	X	----	----
Richard Cole, Agriculture Department	----	----	----	----	----	----	----	----	----	----	X	----	X
R. L. Prichard, Federal Security Agency	----	----	----	----	----	----	----	----	----	----	X	----	----
J. A. McElligott, Agriculture Department	----	X	----	X	X	----	----	----	----	----	----	----	----
A. H. Hedges, Federal Security Agency	----	X	----	----	----	----	----	----	----	----	----	----	----
Dr. Joseph Mountin, U. S. Public Health Service	----	----	----	----	----	X	----	----	----	----	----	----	----
Louise Eskridge, U. S. Public Health Service	----	----	----	----	X	X	----	----	----	----	----	----	----
Mr. Lamb, U. S. Public Health Service	----	----	----	----	----	X	----	----	----	----	----	----	----
Dr. Estella Warner, U. S. Public Health Service	----	----	----	----	----	X	----	----	----	----	----	----	----
Esther Huseman, Federal Security Agency	----	----	----	----	----	X	----	----	----	----	----	----	----
Dr. Ronald Lippitt, Federal Security Agency	----	----	----	----	----	X	----	----	----	----	----	----	----
Tom G. Rathbone, Federal Security Agency	----	----	----	----	----	----	----	----	----	----	X	----	----
Chester B. Lund, Federal Security Agency	----	----	----	----	----	----	----	X	----	----	----	----	----
Dr. Fred Foard, U. S. Public Health Service	----	----	----	----	----	----	----	----	----	X	----	----	----
Chester E. Hazard, Agriculture Department	----	----	----	----	----	----	----	----	----	X	----	----	----
John E. Gross, U. S. Employment Service	----	----	----	----	----	----	----	----	----	X	----	----	----
Miss McIntosh, Federal Security Agency	----	----	----	----	----	----	----	----	----	X	----	----	----

Footnote at end of table.

Exhibit 2.—*Federal employee participation in health-workshop program*—Con.

	Washington, D. C., Nov. 2, 1945	Chicago, Ill., Nov. 26–27, 1945	Washington, D. C., Dec. 10, 1945	Minneapolis, Minn., Dec. 28–29, 1945	Minneapolis, Minn., Jan. 9, 1946	St. Paul, Minn., Feb. 6–10, 1946	Washington, D. C., May 13, 1946	Fargo, N. Dak., July 13, 1946	Great Falls, Mont., July 15, 1946	Denver, Colo., July 17, 1946	Jamestown, N. Dak., Sept. 27–30, 1946	Washington, D. C., Oct. 29, 1946	Aberdeen, S. Dak., Nov. 22, 1946
C. D. Head, Jr., U. S. Public Health Service						X							
*Miss Hollingsworth, Federal Security Agency							X						
Dr. McKneeley, Federal Security Agency							X						
Claire Rosen, Federal Security Agency		X											
Marie Keller, Federal Security Agency		X											
*Statistical clerk, U. S. Public Health Service						X							
*Dr. L. Falk, Pepper committee						X							
Dr. L. Hoyle, Agriculture Department											X		X
Wallace Murdock, Agriculture Department											X		
Walter Murdock, Agriculture Department											X		
Total	10	10	5	1	2	15	9	4	3	5	18	9	2

*Indicates employees from Washington.

Although U. S. Public Health Service is under Federal Security Agency, its employees are listed separately here to show widespread participation of this agency.

Other Federal Security Agency divisions participating included Children's Bureau, Office of Education, Social Security Administration, Office of Vocational Education.

Total number of meetings, 13.

Total number of Federal employees attending, 46.

Total number appearances of Federal personnel, 93.

Total number Washington personnel participating, 20.

Notes on personnel: Becker is with Children's Bureau; Stafford and Klem, Office of Education; Finger was information specialist; Williams and Mountin, Assistant Surgeon General.

Federal agencies participating: Department of Agriculture; U. S. Public Health Service; and the following, under Federal Security Agency—Children's Bureau, Office of Education, U. S. Employment Service, Federal Housing.

Mr. Miller. Then, Mr. Chairman, may I ask permission to read into the record, immediately following the document—and I, of course, have no objection, could properly have no objection to it being entered in the record——

Senator Donnell. I wonder if Mr. Miller would have any objection if I would complete the record in that regard at this point. I would like to put in a little further information that I have here.

Mr. Miller. I will yield to the Senator from Missouri.

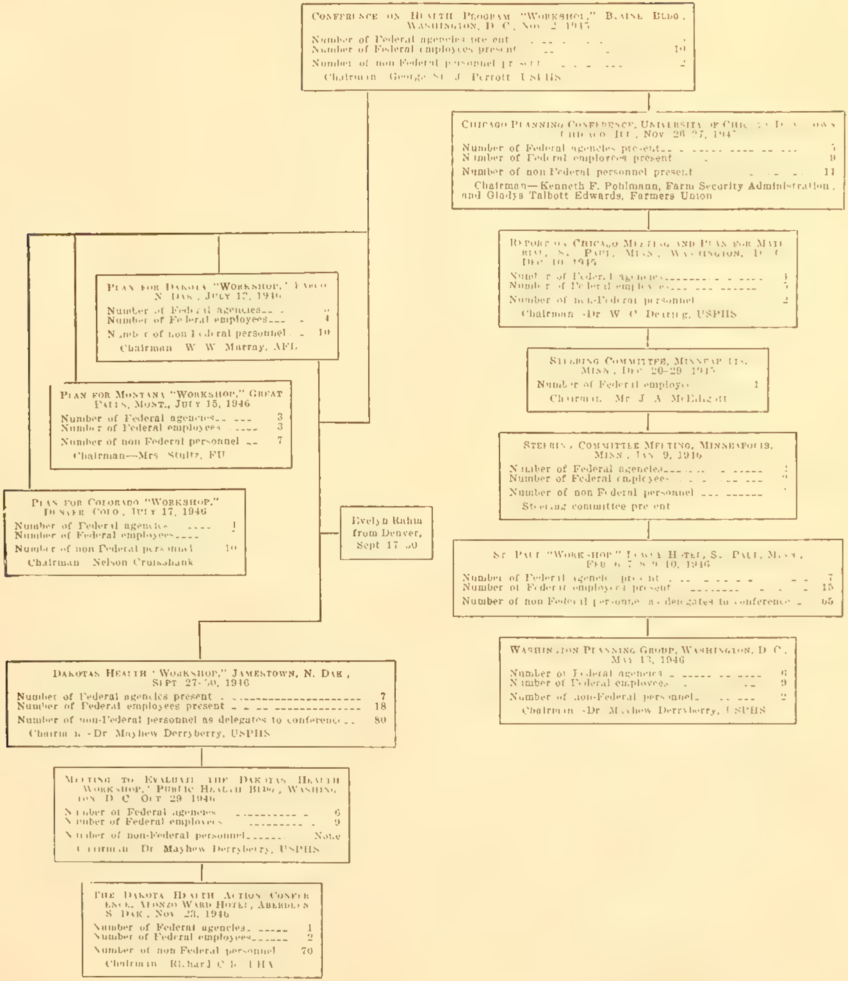
Senator Donnell. I will call attention to the fact, Mr. Chairman, that in the typewritten copy of the testimony before the Committee on Expenditures of the House of Representatives, among the witnesses is Dr. Derryberry. I will ask Mr. Miller if he is health educator in the Public Health Service under the Federal Security Agency?

Mr. Miller. Yes, sir.

Senator Donnell. And Mr.—"Doctor" I presume it is—Herman Hilleboe, he is Assistant Surgeon General in the Public Health Service, in charge of hospital construction and tuberculosis control activities?

Mr. Miller. He is just now on leave of absence as State Commissioner of Health in the State of New York.

Exhibit 2.—*Agency participation in "health workshop" program*



Conference on Health Program "Workshop," Blaine Bldg., Washington, D. C., Nov. 2, 1945
Number of Federal agencies present ..... [illegible]
Number of Federal employees present 10
Number of non-Federal personnel present 2
Chairman—George St. J. Perrott, USPHS

Chicago Planning Conference, University of Chicago, [illegible], Chicago, Ill., Nov. 26–27, 1945
Number of Federal agencies present 5
Number of Federal employees present 9
Number of non-Federal personnel present 11
Chairman—Kenneth F. Pohlmann, Farm Security Administration, and Gladys Talbott Edwards, Farmers Union

Report on Chicago Meeting and Plan for Meeting, St. Paul, Minn., Washington, D. C., Dec. 10, 1945
Number of Federal agencies 4
Number of Federal employees 5
Number of non-Federal personnel 2
Chairman—Dr. W. C. Dearing, USPHS

Steering Committee, Minneapolis, Minn., Dec. 20–29, 1945
Number of Federal employee 1
Chairman—Mr. J. A. McEdagott

Steering Committee Meeting, Minneapolis, Minn., Jan. 9, 1946
Number of Federal agencies ..... [illegible]
Number of Federal employees ..... [illegible]
Number of non-Federal personnel ..... [illegible]
Steering committee present

St. Paul "Workshop," Lowry Hotel, St. Paul, Minn., Feb. 6, 7, 8, 9, 10, 1946
Number of Federal agencies present 7
Number of Federal employees present 15
Number of non-Federal personnel as delegates to conference 65

Washington Planning Group, Washington, D. C., May 13, 1946
Number of Federal agencies 6
Number of Federal employees 9
Number of non-Federal personnel 2
Chairman—Dr. Mayhew Derryberry, USPHS

Plan for Dakota "Workshop," Fargo, N. Dak., July 12, 1946
Number of Federal agencies ..... [illegible]
Number of Federal employees 4
Number of non-Federal personnel 10
Chairman—W. W. Murray, AFL

Plan for Montana "Workshop," Great Falls, Mont., July 15, 1946
Number of Federal agencies 3
Number of Federal employees 3
Number of non-Federal personnel 7
Chairman—Mrs. Stultz, FU

Plan for Colorado "Workshop," Denver, Colo., July 17, 1946
Number of Federal agencies 1
Number of Federal employees ..... [illegible]
Number of non-Federal personnel 10
Chairman—Nelson Cruikshank

Evelyn Rahm from Denver, Sept. 17–30

Dakotas Health "Workshop," Jamestown, N. Dak., Sept. 27–30, 1946
Number of Federal agencies present 7
Number of Federal employees present 18
Number of non-Federal personnel as delegates to conference 80
Chairman—Dr. Mayhew Derryberry, USPHS

Meeting to Evaluate the Dakotas Health "Workshop," Public Health Bldg., Washington, D. C., Oct. 29, 1946
Number of Federal agencies 6
Number of Federal employees 9
Number of non-Federal personnel ..... None
Chairman—Dr. Mayhew Derryberry, USPHS

The Dakota Health Action Conference, Alonzo Ward Hotel, Aberdeen, S. Dak., Nov. 23, 1946
Number of Federal agencies 1
Number of Federal employees 2
Number of non-Federal personnel 70
Chairman—Richard C. [illegible], FHA

e United

ry as to

nildren's

is docu-
dmitted

utset—I

y the sub-
roved and
res in the

nembers,
cord.

e it in a
hich has

In no instance have I felt that I failed in the amenities or in my respect for the Congress. Perhaps a workshop can be likened to what we are doing here this morning.

This document I have here, Mr. Chairman, is dated January 22, 1947, months, of course, before any of us had any indication, any intimation that the activities of workshops would be under examination by the Congress, and I would like to submit it in its entirety for the record, and I think it has something that will even in that period make graphic our feeling about things of this sort. It is a memo to me from the Director of Information, Mr. Zilpha C. Franklin, and says, under date of January 22, 1947:

> The Public Health Service has recently had a request from the Grange and the Farmers' Union, acting jointly, to participate in a forthcoming health workship for organization and community leaders in the States of Washington and Oregon. This project, which would substantially parallel the workshops previously held in Minneapolis and Jamestown, N. Dak., again brings up the question of agency participation in such conferences. In a meeting held in my office on January 7, the questions raised by the Farmers Union letter of October, asking you to set up a workship-unit in the Agency, were again discussed in the light of this new request.
>
> The group agreed that the outstanding asset of such workshops is the two-way opportunity to provide wanted information to alert community and organization leaders and to get from them a first-hand view of public attitudes and interests in the programs with which we are officially concerned. On the debit side must be weighed the expense of sending Agency staff members to such meetings, and the possibility that such participation may be misinterpreted as propagandizing—in spite of the fact that the Government consultants are meticulous in carrying out their instructions to operate solely as sources of factual information. One important question remains unanswered—the extent and effectiveness of what the workshop participants can carry back to their own localities and can communicate to others. Though these end results are not very tangible, the Agency people who took part in the earlier workshops feel that the carry-over to the community is probably substantial. One significant gain seems to have been the demonstration, to State and local health officers, of active and constructive citizen-interest.

The balance of it is subject to my approval that under these circumscriptions certain individuals be permitted to attend these workshops. I would like to have the whole statement placed in the record.

Senator SMITH. It will be admitted.

(The memorandum dated January 22, 1947, follows:)

OFFICE MEMORANDUM, UNITED STATES GOVERNMENT

Date: January 22, 1947.

To: Mr. Watson B. Miller, Administrator.
From: Zilpha C. Franklin, Director of Information.
Subject: Request for Participation in Health Workshop.

The Public Health Service has recently had a request from the Grange and the Farmers Union, acting jointly, to participate in a forthcoming health workshop for organization and community leaders in the States of Washington and Oregon. This project, which would substantially parallel the workshops previously held in Minneapolis and Jamestown, N. Dak., again brings up the question of Agency participation in such conferences. In a meeting held in my office on January 7, the questions raised by the Farmers Union letter of October, asking you to set up a workshop unit in the Agency, were again discussed in the light of this new request.

The group agreed that the outstanding asset of such workshops is the two-way opportunity to provide wanted information to alert community and organization leaders and to get from them a firsthand view of public attitudes and interests in the programs with which we are officially concerned. On the debit side must be weighed the expense of sending Agency staff members to such meetings, and the possibility that such participation may be misinterpreted as propa-

meticulous
l informa-
fectiveness
es and can
ngible, the
carry-over
ns to have
e and con-

ines:
rkshops on
ailable, on
e, for both
n informal
nistrator's

shop. The
cover all
reasonable

ipation ef-
rested con-
ation; and
and to be

e Agency's
restall too
est was so
30 Agency

Senator Donnell. Mr. Chairman, I am practically finished with Mr. Miller.

Senator Murray. Before you proceed, Mr. Chairman, I wish to join with my colleague here in objecting to this line of evidence going into the record. Heretofore I have objected to the presence on this committee of Mrs. Shearon, who has been engaged for some time in spreading this propaganda which was referred to by my colleague, Senator Pepper, a few moments ago. A short time ago, upon our objection, she was discharged from this committee, but she still serves here, and she maintains an office in the Senate Office Building with a large sign on the door advertising herself as a consultant.

Senator Smith. Let me just correct you, if I may, Senator Murray. When Dr. Shearon was discharged, it was understood she was to continue until the hearings were concluded, her services would be discontinued. I think that was the understanding; otherwise, it would appear as though she were here in an unauthorized way.

Senator Donnell. May I interrupt you there, Senator? She is not any longer on the pay roll of this committee.

Senator Murray. But she is disseminating propaganda. She is engaged in sending out propaganda against Members of the Senate who are sponsoring this legislation. As Senator Pepper has called to our attention, she has already spread this propaganda throughout the country by means of this chart which she has prepared, and in which she refers to the Senators who are sponsoring this legislation as collaborationists and fellow travelers. I resent that. I consider her personally obnoxious, and I don't think we should be subjected to these insults. We are Members of this Senate just the same as the chairman and other Members of the Senate are, and I don't think we should be required to sit here and be insulted from day to day by a propagandist who was brought here in the first instance, I understand, by the Republican National Committee, and was on the pay roll of the Republican National Committee. We have investigated her, and we find that she is not a proper or suitable person to be serving on this committee or acting here at all. Because of her unjustified attitude toward us, we resent her presence here, and we think she should be immediately discharged from this room and not permitted to sit at this table along with the Members, in view of her willful misconduct and of the insults she has heaped upon us.

Now, Mr. Chairman, I want to call attention to her record. Dr. Shearon's record since 1934 is a succession of employment with various important Government agencies, each terminated because of her inability to maintain responsible and workable relations with other people. These positions include the New York Department of Social Welfare, New York City Department of Welfare, WPA, Social Security Board, United States Public Health Service. She was also employed for a time by the Senate minority conference group in 1946, and later by the Republican National Committee. During this latter period she indulged verbally, in writing, and through her influence on Members of Congress, in a smear campaign against other Members of Congress, against prominent citizens, and against responsible Government officials. Now, as an employee of the Senate Committee on Labor and Public Welfare, she is continuing to carry on a biased and vindictive lobby. Even though she has been separated from the pay

Building,

nis point:
al of that
have in-
so. Fur-
nting was
record. I
you have
don't see

s entirely

ng here—
at we are
me others.

I don't
o get con-
rences. I
far as I

since she

have her continue on the committee, and he therefore agreed that she should be removed from the pay roll. She further says:

> Senator Taft was unable to obtain a majority vote to retain my services since Senators Morse and Aiken voted with the Democrats for my removal. I am to continue with the committee until the hearings on S. 545 and S. 1320 have been completed and am then to be dismissed.
>
> The day after I cease to be a Senate employee (either July 1 or July 16) I shall resume publication of my weekly releases, American Medicine and the Political Scene, and shall start the other activities described in the announcement herewith. Your support in the fight against state socialism is earnestly solicited.
>
> My professional qualifications include: Ph. D. in pure science, Columbia; Phi Beta Kappa; Sigma Xi; 10 years in scientific research; 12 years in financial management and publicity; 13 years in public administration and research, local, State, and Federal, including 5 years at Social Security Administration, 4 years at Public Health Service, and 2½ years with Senate committees.
>
> MARJORIE SHEARON, Ph. D.,
> *P. O. Box 4034, Chevy Chase, Md.*
>
> JUNE 9, 1947.

Now, I offer this entire chart in evidence and this statement, and also the additional material which she has sent out with this letter to the people that she addressed this communication to. I also wish to have this statement included in the record.

(The chart referred to appears hereafter in pt. 4.)

Senator DONNELL. Have you finished, Senator Murray?

Senator MURRAY. I also ask to have these clippings put into the record at this point, one from the St. Louis Post Dispatch, by Edward A. Harris, Washington correspondent of the Post Dispatch, discussing this situation.

Senator DONNELL. What is the date of that?

Senator MURRAY. January 18.

Senator DONNELL. This year?

Senator MURRAY. It is dated Washington, January 18, this year, 1947.

I want to call attention also to the fact that the American medical profession objects to Mrs. Shearon, and points out that she is unstable, and that they have written in some of their medical journals criticisms of her. I have two here, one an excerpt from the Rocky Mountain Medical Journal of October 1946, volume 43, No. 10, page 798, which I will put into the record at this point; also an excerpt from Medical Annals for November 1946, pages 558–559, entitled "The Lady Who Knows"; also an article by Nelson H. Cruikshank entitled "Playing Politics With Health," in the American Federationist, page 24, the entire article.

(The material submitted by Senator Murray follows:)

ANNOUNCING ESTABLISHMENT OF THE SHEARON MEDICAL LEGISLATIVE SERVICE, WASHINGTON, D. C., JULY 1, 1947

OBJECTIVES

1. To furnish concise, timely, analytical information about current Federal legislative proposals in the fields of health and medicine, with special emphasis on compulsory sickness insurance legislation;
2. To issue weekly releases entitled "American Medicine and the Political Scene" while Congress is in session;
3. To conduct research in the social, economic, and legislative aspects of medicine and to make available to subscribers the results of such research;

r the bene-
tion to the

f testimony
vices to be
o insurance
d individu-
ree medical

lism in the
nce as part
ulation pat-

ting such a
e chips fall
party label,
mplications
controlled

ntimidated,
not shaped
tent that a
an opposing

in the fight
t good, old-

FINANCES

I seek immediate financial support to enable me to carry out these objectives and plans. I desire support on a wide base, rather than large subsidies from a few organizations or individuals. I require funds at once for office furniture and equipment. A lease must be signed. A small staff, including an executive secretary, research assistant, news gatherer, secretary, and mimeograph operator, must be employed. Sustaining funds are needed to pay for office upkeep and to cover cost of material distributed free of charge to Members of Congress, to the press, and to civic leaders for educational purposes.

SUBSCRIPTION RATES

Support for the objectives listed above is sought on the following bases:

	Annual rate
Sustaining subscriptions, including right to all material published	$500
Organization subscriptions:	
Large organizations requiring diversified services	200
Small organizations with limited needs	100
Individual subscriptions entitling to at least 35 releases a year	15
Consultative services on a fee-for-service basis	--

MARJORIE SHEARON, Ph. D.,
P. O. Box 4034, Chevy Chase 15, Md.

JUNE 9, 1947.

SUBSCRIPTION BLANK

MARJORIE SHEARON, Ph.D.
P. O. Box 4034, Chevy Chase 15, Md.

I hereby subscribe for 1 year beginning July 1, 1947, to the Shearon Medical Legislative Service, to be established in Washington, D. C., between July 1, and July 15, 1947.

I enclose my check for $ ________ for the subscription indicated below:

Check ( )	*Annual rate*
— Sustaining subscription, entitling subscriber to 10 copies of each weekly news release and to 1 copy of all material published	$500
Organization subscription:	
— For large organizations requiring diversified services and 10 copies of weekly news release for officers	200
— For smaller organizations with limited needs and requiring only 5 copies of weekly news release	100
— Individual subscriptions entitling individuals to 1 copy of weekly news release and to minor services	15

NOTE.—American Medicine and the Political Scene, the weekly news release referred to, will be published not less than 35 times a year—throughout regular sessions of Congress and for about 2 weeks before and after Congress convenes. Sustaining and organization subscriptions may be paid on a semiannual basis if desired. Special services will be billed on a fee-for-service basis. Prices on quantity lots of publications will be quoted as material is printed.

Name ______________________________
Address: ___________________________

[From the Post-Dispatch, St. Louis, Mo., January 19, 1947]

LOBBYISTS OFFER OF RESEARCH AID AGAINST HEALTH BILL DISCLOSED—GOP EMPLOYEE WORKING ON MEASURE FOR SENATORS SAYS SHE REJECTED PROPOSAL OF PHYSICIANS AGENT

(By Edward A. Harris, a Washington Correspondent of the Post-Dispatch)

WASHINGTON, January 18.—A letter that has been circulating around Washington for some time discloses that a lobbyist of the physicians' group fighting the Wagner-Murray-Dingell health insurance bill made an offer of free research al contri-

ade, Mrs.
ommittee
committee
uilding.
vho is an

ars, is an
ch of her
bill. She
mmittee's

Ohio, new
ll, Repub-
last year
g Senator
ll held by
ive meas-
y-Dingell

were sent
group of
bilized to
edical As-
onal body

donor, not the NPC, to make a contribution to the Republican National Committee so that she would have more funds for clerical aid in carrying on her fine work in the interest of progressive medical legislation.

"She telephoned her research superior in the national committee, while I was sitting there, and he agreed with her that it could not be done. That ended the matter so far as I was concerned."

MRS. SHEARON INDIGNANT

Mrs. Shearon said in her letter that she felt considerable indignation that Stegen had dared to make his suggestion.

"I believe," she wrote, "there is not a single reputable physician who would thus have proposed, none too subtly, to purchase a lien on my professional services to Republican Senators."

She said she "could not but wonder" if Stegen thought she was naive, or devious, or "downright crooked," and secondly, "whether he was expanding the influence of the NPC by making similar propositions to other persons who, in his estimation, might prove useful. Surely he knew exactly what he was doing and what was implicit in his offer."

Mrs. Shearon told the Post-Dispatch that the letter, sent last August 9, stirred up a hornet's nest within the NPC and efforts were made to have her relieved of her job. The proposition had been made to her by Stegen last April, she said.

"PURELY LOBBYING GROUP"

"Senator Taft told me we should not get involved in medical politics," said Mrs. Shearon, "and I shouldn't be talking about it now. But the NPC tactics make me so furious. For one thing it's ridiculous for the NPC to pretend that it isn't associated with the American Medical Association, and for another, to pretend it's an educational instead of a purely lobbying group. Their men here just don't have the facts in their fight on the Wagner-Murray-Dingell bill, and they resort to distortions, misstatements, and downright falsifications."

Her vitriolic letter was mailed, she said, without prior consultation with Senators Taft or Donnell or anyone else. She said she used official envelopes of Senator Taft in mailing them, but bought her own stamps.

Other highlights of her letter included the statement that she is completing a booklet on the proposed "nationalization" of medicine to be mailed by the Republican National Committee to every doctor and dentist in the Nation; the assertion that NPC has supplied the medical profession and the public with "sheer buncombe" in its propaganda; sharp criticism of the NPC for having "its legislative lobbying activities financed in considerable measure" by the drug industry; and the statement that the NPC's "paid staff of promoters" has done many things that would "horrify" the group's board of directors if it knew what went on.

The tone of the entire seven-page, single-spaced letter reflected the researcher's firm opinion that the NPC might do well to abandon its own methods of working against the Wagner-Murray-Dingell bill in favor of open, above-board techniques.

She made it clear that she considered herself the most fully qualified person to expose the "dangers" of the measure. She offered her services as a speaker before medical groups, saying that while the Republican National Committee would pay her traveling expenses in whole or in part, she preferred to have the sponsoring group do so.

Senator Taft, at whose instance she said she was first employed by the GOP, has approved her acceptance also of "honorarium for speeches and fees for articles." While at no time is such payment required or expected, she went on, on the other hand, "no group should think my speech will be influenced in any way by an honorarium."

Mrs. Shearon, who told recipients of her letter there was "nothing official" in her remarks, is a doctor of philosophy in science, and formerly worked for 5 years with the Social Security Board and 4 years with the Public Health Service.

NONPOLITICAL, NONPROFIT

The full name of the NPC is the National Physicians' Committee for the Extension of Medical Service, with main offices at 75 East Wacker Drive, Chicago.

Its letterhead states that it is a "nonpolitical, nonprofit organization for maintaining ethical and scientific standards and extending medical service to all the people."

r-Murray-
ributed to

anuary 5,

out solu-
al regula-
annually."
ss league"

, p. 798]

s to hear
ne Confer-
t occurred
at Estes
nong them
ed a terri-

meetings.
pent what
personal
were also
direct dis-
erpret the
seemed to

the Government, she has made her opinions known whenever the occasion offered.

Along in the early summer of 1946, Mrs. Shearon issued bulletins devoted to health legislation. These were more than factual reports. They indicated how deeply Mrs. Shearon felt about opponents of organized medicine. Medicine's cause became hers, and she had stronger convictions about what should be done than most doctors. Critical of the representatives of organized medicine, and especially those who she said were paid for the purpose of "guarding its interests," she warned that the medical profession is in "an extremely weak position in combating the forces now working for the destruction of the private practice of medicine."

What she called the House of Falk, however, was the principal object of her attack. Here she laid down her heaviest verbal barrage. Unfortunately, the length to which Mrs. Shearon went to discredit Mr. Falk invalidated some of her otherwise sound arguments.

Under date of August 9 she issued a bulletin in which she set forth at length her qualifications for the role in which she had been cast. These were impressive enough, and several medical societies invited her to speak to them. One of these was the Michigan Medical Society.

Albert Deutsch of the loud leftist newspaper PM who baits organized medicine whenever the opportunity offers, covered the meeting addressed by Mrs. Shearon in Michigan. As usual, he went at his assignment without gloves. Mrs. Shearon, he cried, "put the finger on Fishbein and other alleged participants in this international plot," the plot being to turn the world over to "Joe" Stalin. Mr. Falk came in for special attention. "Now this fellow Falk," Mrs. Shearon is quoted as saying, "is the most dangerous man in America. He is very, very clever, and a master of intrigue." Michael M. Davis and others she considered "nearly as dangerous." Finally, according to Mr. Deutsch, she got around to Dr. Fishbein, who, she is said to have related, is often seen in Washington in company of known advocates of compulsory sickness insurance. "I don't trust Fishbein," she is reported as saying. In fact, she is said have added that Dr. Fishbein and Mr. Falk are "like two peas in a pod. I would like to see them both dumped into the river."

Mr. Deutsch chided doctors present for applauding Mrs. Shearon's "flights into fantasy."

As these lines are being written, an announcement of Mrs. Shearon's appearance before another medical society came to your observer's attention. She is listed on the program as "The Lady Who Knows the Sinister Implications of Socialistic Medicine."

Playing Politics With Health

(By Nelson H. Cruikshank, director, A. F. of L. social insurance activities)

"When I think how every labor bill was suppressed during those years in which your party maintained control and you were chairman, and when I think of the general procedure of this committee to put across that general plan, I certainly am surprised at the attitude you have taken this morning when we take the opportunity, when we have control of the committee, to present our case first."

The speaker is Senator Robert A. Taft, chairman of the Senate Committee on Labor and Public Welfare. The scene is the big committee room in the Capitol where hearings have just opened on Senator Taft's charity health bill before a subcommittee. The time is the morning of May 21, 1947.

Senator James A. Murray, of Montana, former chairman of the committee, has just raised an objection to the manner in which the hearings are being conducted, charging that more than nine-tenths of the scheduled time of the hearings has been assigned to organizations opposed to health insurance of the kind envisaged in the bill which he and Senators Wagner, McGrath, Chavez, and Pepper have just introduced. He has pointed out that less than 2 hours of time have been allowed organizations representing millions of people who are expected to be opposed to the proposals embodied in Senator Taft's bill.

In order fully to appreciate the significance of this little drama one needs to know what has been going on behind the scenes in this subcommittee for the past several months. It is because the implications of this story have a significance that goes beyond the treatment of the health proposals that I believe the readers of the Federationist will be interested in the whole story.

It started last year during the hearings on S. 1606, the National health-insurance bill. At those hearings Senator Donnell, of Missouri, submitted every

n. At his
ates Public
, who con-
e obviously
hen in the
committee

bill of last
onal Com-
of pamph-
insurance
y that had
al Security
onal Labor
r organiza-
n carefully
ttee, these
ck.
went to a
re opposed
ht control
tivity, but
ople whom
o the kind
ved copies
ce at least.

the Repub-
lic Health
evidently

Thus it was that when Senator Murray pointed out at the opening sessions of the hearings that almost all the time was being given to advocates of Senator Taft's public charity health bill, Senator Smith could accurately respond that time was being given to those who had requested to be heard on the Taft bill. Of course, many opponents of health insurance and supporters of a medical poor law of the kind proposed by Senator Taft had asked to be heard, as they were directed to do so by Dr. Shearon. The result is that practically all the time during the first 4 weeks of the hearings is now being given to supporters of the Taft bill, with no time allotted to the opponents, whereas all the supporters of genuine health insurance, including the American Federation of Labor, are to be crowded into 3 days after the hearings on the Taft bill are completed.

There are other implications of Senator Taft's statement which need to be examined. What are the facts with respect to his charge that the hearings last year were stacked against his bill?

In the first place, he charges that supporters of his bill last year were not heard until the end of the hearings. But the hearings last year began on April 2, and it was more than a month later when Senator Taft introduced his bill. He could hardly expect that time would be given the proponents of a bill which had not yet been introduced. This year both bills were introduced prior to the opening hearings.

Looking at the schedule of last year's hearings, we find that supporters and opponents of health insurance were heard regularly throughout the hearings. Although supporters outnumbered the opponents, the opponents were not put off until the end of the hearings. Representatives of the American Medical Association, of so-called voluntary health plans, and of State medical societies were heard during the second week of the hearings, which lasted 6 weeks.

Incidentally, in connection with last year's bill, Senator Taft indicated to representatives of the American Federation of Labor that he was planning to introduce such a bill and said that he would like to discuss its contents with them prior to its introduction. This, however, he failed to do, and no representative of the American Federation of Labor was consulted prior to the introduction of the bill, either this year or last.

Last January I personally talked with Senator Taft about the possibility of health legislation this year. He stated at that time that he was discussing a new bill with "interested persons." I suggested that the 7,500,000 members of the American Federation of Labor and their families who would be affected by any health legislation might properly be included among the interested persons. He brushed this off by saying:

"Your organization represents some of the interested persons."

To what does Senator Taft refer when he says: "We have control of the committee"? He could have meant and probably meant only to imply that a majority of the Subcommittee on Health is now composed of members of his party; namely, Senators Smith, of New Jersey; Ball, of Minnesota; and Donnell, of Missouri. But in the hearings there were indications that his statement meant more than he intended to imply, for on the opening day Dr. Ross Sensenich, chairman of the board of trustees of the American Medical Association, stated that his organization had been consulted in drafting the final form of the bill and indicated that many of the suggestions made by the AMA had been incorporated. So, in health as in labor legislation, Senator Taft listens to the reactionary forces that have a direct stake in denying the progress the people are demanding. The NAM writes his labor bills and the AMA his health bills.

Or perhaps Senator Taft is listening to the National Physicians Committee, the propaganda arm of organized medicine, which, according to the records of registration required by the Lobbying Act, spent $306,000 during the last 5 months of 1946 in smearing and attacking national health insurance.

The issues between the two bills now before the committee are clearly drawn and the stakes are high. The stakes are more than financial. They involve the opportunity for working people over the Nation to obtain adequate medical care of high quality as a right and in a manner consistent with the dignity and self-respect of free workers in a democracy, as opposed to the proposal to provide through State machines dominated by medical politicians a minimum of medical care doled out as a public charity.

The health-insurance bill (S. 1320) would provide to all employed and self-employed persons and the members of their families as soon as personnel and facilities are available all needed preventive, diagnostic, and curative

specialists
nd special
ances, and
be limited
rvices for

dentist, or
persons to
inistration
epresenta-
ally repre-
oup-health
greements.
contribu-
somewhat
l services
l revenues

eally spent
ing of the

ne part of
one—the
rvices and
h centers,
additional
or crippled
for public

proposes to

Senator Smith. Yes.

(The document referred to will appear in pt. 4.)

Senator Donnell. The Blueprint does contain the language at the top of the chart:

> Administration plans for nationalization of medicine, emanating from the House of Falk. Spheres of influence and interlocking directorates, collaborationists, fellow travelers, appeasers, satellites, and gullible accepters.

I am informed by Dr. Shearon that by the term "collaborationists" and "fellow travelers" she was referring to collaboration and traveling along with Mr. Falk, Isidore Falk.

I may call attention to the fact that the left-hand lower portion of this Blueprint is this legend "Direct line of control." That shows a black line from direct lines of control on staff of or consultant to I. S. Falk, i. e., on Federal pay roll. Then a broken line and—

> Indirect lines of control: Collaborationists, fellow travelers, appeasers, satellites, and gullible accepters.

I call attention to the further fact that it is my information from Dr. Shearon that approximately only 10 of these Blueprints were printed, that she does not know how this particular one came into the possession of either Senator Murray or Senator Pepper; but I offer it in the record at this time, Mr. Chairman, a copy taken from the booklet marked "Blueprint for the Nationalization of Medicine," by Marjorie Shearon, Ph. D., research analyst.

I offer for the record a similar print entitled "Administration Plans for Nationalization of Medicine, emanating from the House of Falk," in which I call attention that immediately under "the House of Falk" instead of the words "Spheres of influence and interlocking directorates, collaborationists, fellow travelers, appeasers, satellites, and gullible accepters," the words on this are: "Spheres of influence and interlocking directorates," and all reference to collaborationists and fellow travelers, appeasers, satellites, and gullible accepters has been omitted from this print that appears in this Blueprint issued in Washington in 1947.

Senator Smith. You are offering that in connection with matter referred to by Senator Murray?

Senator Donnell. That is correct.

(The paper referred to will appear in pt. 4.)

Senator Donnell. I also would like at this time to ask the reporter—I want this to go into the record—if he will be kind enough at his earliest convenience to look at page 1647 of the record of these hearings, at which page appears this question and answer:

> Senator Murray. Then what right has she to be here?

I may interrupt there to say that "she" is Dr. Shearon. Then this appears by myself:

> Senator Donnell. She is here.

My recollection is, Mr. Chairman, and my best judgment is that there is an error in the report of my statement "She is here." I think that what I said was substantially "She is assisting me," or perhaps "She is here assisting me." I am not asking the reporter to change the record. If he doesn't find that in his notes I want it to stay as it is, but nevertheless I will ask him if he will be kind enough to examine the record and let me know whether or not there should be

that the
re to state
g curt or
said, and
ne.
plied the

ator said,
' I have
few pages
other day
ne places.
t Senator
the fact
you were
was the
ng at the
ne record,
it. She
We could
so rapid
nent half
l be made
te record

discourtesy that she has intended in the course of these hearings at any time to any member of the committee. She has been extremely helpful, and it appears to me it would be decidedly improper for her to be removed. I ask very respectfully that she be permitted to remain and assist. She is on the staff, so I am informed by her, and I believe it to be true, of Senator Taft, and I think she has a right to be of any assistance to Senator Murray or Senator Pepper or Senator Smith or any other member of this committee. No discourtesy is intended to either of these gentlemen. They have been so courteous and very gentlemanly at all times to me, and I assure them of my appreciation of it.

Senator SMITH. I would like to say at this point, I was not present when this difficulty came up the other day so I am not familiar with it, but as far as I am concerned, I have heard nothing done in the presence of the committee or in the hearings by Dr. Shearon along the line of these accusations. As to these documents here, I have not had time to examine them, but I can say to the Senator that had anything discourteous happened at these hearings, I should have protected the Senator from Montana and from Florida, as well as anybody else. Senators are entitled to the greatest respect, and nothing has been done that I have seen in the presence of the committee, and I requested Dr. Shearon not to send out these statements after they were called to the attention of the committee, and I understand that that request has been carried out. I certainly agree that we should keep away from propaganda in this matter. What we are after is facts, and we must have facts before we can get results in the way of legislation, and it is very distressing to me to have an issue of this kind come up, especially when I think there is only one more day of hearings, maybe two more, and we are about through, and it seems to me that we can work this out without attendant publicity and difficulty. I am perfectly willing to take the matter up before the whole committee, and I think that is where it belongs, and I want to respectfully say to the Senators from Montana and Florida that I have had nothing presented to me that would justify me in saying that Dr. Shearon at this moment should leave the room. I think that is utterly unfair for the Senators to ask me to do that, and I would have to very respectfully decline to do it, but I assure you I am going to do everything in my power to see that matters of this nature do not come up when we are trying to get at the facts.

Senator MURRAY. I sympathize with the Senator, and I appreciate his expressions here, but the Senator will recall that when we had the matter up before the executive meeting of the committee it was conceded then that her actions were improper, and that she would not be permitted to continue on the committee, but at the special request of Senator Donnell, I believe, she was permitted to remain.

Senator SMITH. I made the request that Dr. Shearon assist us in getting information.

Senator MURRAY. But with the understanding that she was to desist in these propaganda activities that she has been engaged in. But she did not desist. I have seen statements that she has sent out subsequent to that time, and I suspect she is sending out material every day.

Senator PEPPER. It may be that the Senator would prefer to make a decision about this matter in executive session.

Senator SMITH. I would prefer it.

e Senator
n up and

he House
oduced in
partment
espect to:

e Supreme
ccusations
to intimi-
n resisting

agraph, I
wing the
e United
p Health
r that the
d in this

my part

e Senator
that this

is not upon the Department of Justice or the Supreme Court, but is upon the American Medical Association or the Group Health Association of Washington, D. C., and I am sure the Senator did not mean to indicate that there was any reflection here against either the Department of Justice or the Supreme Court.

Senator Pepper. The Senator from Florida may be misunderstood, but it was his intention to say that he cannot construe that language other than to conclude that it was the desire and intent on the part of that committee to include the action of the Department of Justice and the Supreme Court as particeps criminis with the action, which they denounce, of the Group Medical Association in Washington. The report, of course, will have to speak for itself, but the Senator did intend to say that the report was intended to bring the Supreme Court, the Department of Justice and the Group Health Association all together in condemnation, because it says this served effectively to intimidate and restrain the activities of the American Medical Association, not intimidation from violating the antitrust laws, but it says "in resisting the Federal propaganda"—that decision of the United States Supreme Court effectively prevented them from resisting the Federal propaganda.

Senator Donnell. I have no objection to including it in the record.

Senator Smith. You do not have them here?

Senator Pepper. I will furnish them.

Senator Donnell. May I make one further suggestion, that is, that all of these documents, House Report 786, and the other papers that have been introduced, be incorporated in the record at the places where presented, so that we do not have to look back at an appendix somewhere to find it.

Senator Pepper. It should appear in the regular order.

Senator Smith. Are there any further questions?

Senator Donnell. I have no further questions.

Senator Smith. The committee will recess until 2:30 this afternoon, and Dr. Parran will proceed at that time.

(Whereupon, at 1:15 p. m., the subcommittee recessed until 2:30 p. m., this day.)

(The decision of the United States Supreme Court in the action referred to follows:)

SUPREME COURT OF THE UNITED STATES.

Nos. 201–202.—October Term, 1942.

American Medical Association, a corporation, Petitioner,
201 *vs.*
The United States of America.
The Medical Society of the District of Columbia, a corporation, Petitioner,
202 *vs.*
The United States of America.

On Writs of Certiorari to the United States Court of Appeals for the District of Columbia.

[January 18, 1943.]

Mr. Justice Roberts delivered the opinion of the Court.

Petitioners have been indicted and convicted of conspiring to violate § 3 of the Sherman Act,[1] by restraining trade or commerce in the District of Columbia.

---

[1] Act of July 2, 1890, § 3, c. 647, 26 Stat. 209, 15 U. S. C. § 3.

Columbia.
tions and
e or other
District of
on various
and with

conspiracy
nc., a non-
dical care
employed
es for the
ry to the
ent Group
erce prac-
ent under
ners, from
vith them,
affording

e grounds,
of Group
the Court
he statute
p Health.[8]
ants were
submitted
lefendants
the Court
e Sherman

310 U. S. 469. But nothing in that decision contradicts the proposition stated. Whether the conspiracy was aimed at restraining or destroying competition, or had as its purpose a restraint of the free availability of medical or hospital services in the market, the *Apex* case places it within the scope of the statute.[7]

Second. This brings us to consider whether the indictment charged, or the evidence proved, such a conspiracy in restraint of trade. The allegations of the indictment are lengthy and detailed. After naming and describing the defendants and the Washington hospitals, it devotes many paragraphs to a recital of the plan adopted by Group Health and alleges that, principally for economic reasons, and because of fear of business competition, the defendants have opposed such projects.

The indictment then recites the size and importance of the petitioners, enumerates means by which they can prevent their members from serving Group Health plans, or consulting with physicians who work for Group Health, and can prevent hospitals from affording facilities to Group Health's doctors.

In charging the conspiracy, the indictment describes the organization and operation of Group Health and states that, from January 1937 to the date of the indictment, the defendants, the Washington hospitals, and others cognizant of the premised facts, "have combined and conspired together for the purpose of restraining trade in the District of Columbia, . . ." In five paragraphs the pleading states the purposes of the conspiracy. The first is the purpose of restraining Group Health from doing business; the second, that of restraining members of Group Health from obtaining adequate medical care according to Group Health's plan; the third, that of restraining doctors serving Group Health in the pursuit of their calling; the fourth, that of restraining doctors not on Group Health's staff from practicing in the District of Columbia in pursuance of their calling; and the fifth, that of restraining the Washington hospitals in the business of operating their hospitals.

After reciting certain of the proceedings and plans adopted to forward the conspiracy, the indictment alleges that the conspiracy, and the intended restraints which have resulted from it, have been effectuated "in the following manner and by the following means"; and alleges that the defendants have combined and conspired "with the plan and purpose to hinder and obstruct Group Health Association, Inc. in procuring and retaining on its medical staff qualified doctors and to hinder and obstruct the doctors serving on that staff from obtaining consultations with other doctors and specialists practicing in the District of Columbia." It states that, pursuant to this plan and purpose, the defendants have resorted to certain means to accomplish the end, and recounts them.

In another paragraph, the defendants are charged to have conspired with "the plan and purpose to hinder and obstruct Group Health Association, Inc. in obtaining access to hospital facilities for its members and to hinder and obstruct the doctors on the medical staff of Group Health from treating and operating on their patients in Washington hospitals." It is alleged that, pursuant to this plan and purpose, defendants have done certain acts to deter hospitals with which they were connected and over which they exercised influence, from affording hospital facilities to Group Health's doctors.

The petitioners' contention is, in effect, that the indictment charges five separate conspiracies defined by their separate and recited purposes, namely, conspiracy to obstruct the business of Group Health, to obstruct its members from obtaining the benefit of its activities, to obstruct its doctors from serving it, to obstruct other doctors in the practice of their calling, and to restrain the business of Washington hospitals. The petitioners say that they were entitled to have the trial court rule upon the sufficiency in law of each of these charges and, as this was not done, the general verdict of guilty cannot stand. They urge that even though some of the named purposes relate to the business of Group Health, and that business be held trade within the meaning of the statute, yet, as the practice of medicine by doctors not employed by Group Health is not trade, and the operations of Washington hospitals are not trade, the last two purposes specified cannot constitute violations of § 3 and the jury should have been so instructed. In this view they insist that the jury may have convicted them of restraining physicians unconnected with Group Health, or of restraining hospitals, and, if so, the verdict and judgment cannot stand.

If in fact the indictment charges a single conspiracy to obstruct and restrain the business of Group Health, and if the recited purposes are really only subsidiary to that main purpose or aim, or merely different steps toward the acne jury on

---

[7] Compare Fashion Originator's Guild *v.* Federal Trade Commission, 312 U. S. 457, 465, 466, 467.

onstructed
ne charge,
conspired
e steps by
traints on
ual expul-
l contacts
ocieties to

cision and
arged but

It is true
conspiracy
rging part
l obstruct
which are
calling the
ne charge,

measures
oyment of
ts medical

reasonable
trict in at

Section 13 of the Norris-LaGuardia Act defines a labor dispute as including "any controversy concerning terms or conditions of employment, or concerning the association or representation of persons in negotiating, fixing, maintaining, changing, or seeking to arrange terms or conditions of employment, regardless of whether or not the disputants stand in the proximate relation of employer and employee." It also provides that "A case shall be held to involve or to grow out of a labor dispute when the case involves persons who are engaged in the same industry, trade, craft, or occupation; or have direct or indirect interests therein; or who are employees of the same employer; or who are members of the same or an affiliated oragnization of employers or employees; whether such dispute is (1) between one or more employers or associations of employers and one or more employees or associations of employees; (2) between one or more employers or associations of employers and one or more employers or associations of employers; or (3) between one or more employees or associations of employees and one or more employees or associations of employees; or when the case involves any conflicting or competing interests in a 'labor dispute' (as defined in this section) of 'persons participating or interested' therein (as defined in this section)."

Citing these provisions the petitioners insist that their dispute with Group Health was as to terms and conditions of employment of the doctors employed by Group Health since the District Medical Society objected to its members, or other doctors, taking employment under Group Health on the terms offered by that corporation. They assert that § 20 of the Clayton Act, as expanded by § 13 of the Norris-LaGuardia Act, includes all persons and associations involved in a dispute over terms and conditions of employment who are engaged in the same industry, trade, craft, or occupation, or have direct or indirect interests therein. And they rely upon our decisions in *New Negro Alliance* v. *Sanitary Grocery Co.*, 303 U. S. 552, and *Drivers Union* v. *Lake Valley Co.*, 311 U. S. 91, as bringing within the coverage of the acts a third party, even though that party be a corporation not in trade, and employers and employees' associations even though they be only indirectly interested in the controversy. They insist that as the petitioners and Group Health, its members and doctors, other doctors and the hospitals, were either directly or indirectly interested in a controversy which concerned the terms of employment of doctors by Group Health, the case fails within the exemption of the statutes and they cannot be held criminally liable for a violation of the Sherman Act.

It seems plain enough that the Clayton and Norris-LaGuardia Acts were not intended to immunize such a dispute as is presented in this case. Nevertheless, it is not our province to define the purpose of Congress apart from what it has said in its enactments, and, if the petitioners' activities fall within the classes defined by the acts, we are bound to accord petitioners, especially in a criminal case, the benefit of the legislative provisions.

We think, however, that, upon analysis, it appears that petitioners' activities are not within the exemptions granted by the statutes. Although the Government asserts the contrary, we shall assume that the doctors having contracts with Group Health were employes of that corporation. The petitioners did not represent present or prospective employes. Their purpose was to prevent anyone from taking employment under Group Health. They were interested in the terms and conditions of the employment only in the sense that they desired wholly to prevent Group Health from functioning by having any employes. Their objection was to its method of doing business. Obviously there was no dispute between Group Health and the doctors it employed or might employ in which petitioners were either directly or indirectly interested.

In truth, the petitioners represented physicians who desired that they and all others should practice independently on a fee for service basis where whatever arrangement for payment each had was a matter that lay between him and his patient in each individual case of service or treatment. The petitioners were not an association of employes in any proper sense of the term. They were an association of individual practitioners each exercising his calling as an independent unit. These independent physicians, and the two petitioning associations which represent them, were interested solely in preventing the operation of a business conducted in corporate form by Group Health. In this aspect the case is very like *Columbia River Packers Association, Inc.*, v. *Hinton*, 315 U. S. 143. What was there decided requires a holding that the petitioners' activities were not exempted by the Clayton and the Norris-LaGuardia Acts from the operation of the Sherman Act.

The judgments are affirmed.

considera-

urt, U. S.

Columbia

OLUMBIA

PPELLANT

f Columbia

evidenced by the following statement from their brief: "The *Apex* case held in substance and effect that no activity could be in 'trade' unless it was a commercial activity and exercised and used in such a way as to affect the market either by fixing prices or suppressing competition in the market to the injury of the public." Of course the Court did not so hold, nor has any court ever so held. Most activities which are in trade serve, rather than injure, the public.

In the *Apex* case,[3] no question was involved as to whether the petitioner was engaged in trade or commerce. The opening sentence of the opinion states, as an undisputed fact: "Petitioner, a Pennsylvania corporation, is engaged in the manufacture, at its factory in Philadelphia, of hosiery, a substantial part of which is shipped in interstate commerce." Neither was the Court in doubt as to whether trade or commerce was affected by the actions complained of.[4] The question which was presented for its decision was whether the conduct of the labor union and its members constituted *restraint* of trade, within the meaning of Section 1 of the Sherman Act.[5]

In answering this question, the Court, first, restated the familiar common law doctrines relating to contracts and combinations in restraint of trade and the equally familiar history of the taking over, by the Sherman Act, of the common law concept of illegal restraints.[6] It then concluded that (1) the Sherman Act does not condemn all combinations and conspiracies which interrupt interstate transportation;[7] (2) labor unions are to some extent and in some circumstances subject to the Act;[8] but (3) it does not apply to all labor union activities affecting interstate commerce![9] (4) the evil at which the Sherman Act was aimed was the control of the market "by suppression of competition in the marketing of goods and services . . .";[10] (5) the end sought was the prevention of "restraints to free competition in business and commercial transactions which tended to restrict production, raise prices or otherwise control the market to the detriment of purchasers or consumers of goods and services . . .";[11] and, finally (6) "Restraints on competition or on the course of trade in the merchandising of articles moving in interstate commerce is not enough, unless the restraint is shown to have or is intended to have an effect upon prices in the market or otherwise to deprive purchasers or consumers of the advantages which they derive from free competition."[12]

The trade or commerce which was involved in the present case was of three kinds: (1) The making available and financing of medical and hospital services; (2) medical service itself, *i. e.*, service rendered by medical doctors; (3) hospital service, *i. e.*, service rendered by hospital staffs and the use of hospital facilities. As we indicated in our earlier opinion the common law recognized the practice of medicine as being trade[13] and there is nothing in the *Apex* case to suggest the contrary. It may be regrettable that Congress chose to take over in the Sherman Act the common law concept of trade, at least to the extent of including therein the practice of medicine. Developments which have taken place during recent decades in the building up of standards of professional education and licensure, together with self-imposed standards of discipline and professional ethics, have, in the belief of many persons, resulted in substantial

---

[3] 310 U. S. 469, 480.

[4] Apex Hosiery Co. v. Leader, 310 U. S. 469, 484; "Cessation of petitioner's manufacturing operations, which respondents compelled, indubitably meant the cessation of shipment interstate. The effect upon the commerce resulted naturally and inevitably from the cause. The occupancy of petitioner's factory by the strikers prevented the shipment of the substantial amount of merchandise on hand when the strike was called. In point of the immediacy of the effect of the strikers' acts upon the interstate transportation involved and of its volume, the case does not differ from many others in which we have sustained the Congressional exercise of the commerce power."

[5] Apex Hosiery Co. v. Leader, 310 U. S. 469, 487, 490: ". . . the question to which we must address ourselves is whether a conspiracy of strikers in a labor dispute to stop the operation of the employer's factory in order to enforce their demands against the employer *is the kind of restraint of trade* or commerce at which the Act is aimed . . . Since in the present case, as we have seen, the natural and predictable consequence of the strike was the restraint of interstate transportation the precise question which we are called upon to decide is whether *that restraint* resulting from the strike maintained to enforce union demands by compelling a shutdown of petitioner's factory *is the kind of 'restraint of trade or commerce'* which the Act condemns." [Italics supplied.]

[6] Apex Hosiery Co. v. Leader, 310 U. S. 469, 497–498.

[7] Apex Hosiery Co. v. Leader, 310 U. S. 469, 486, 491.

[8] *Id.* at 489.

[9] *Ibid.*

[10] *Id.* at 493.

[11] *Ibid.* and see n. 15.

[12] Apex Hosiery Co. v. Leader, 310 U. S. 469, 500–501.

[13] United States v. American Medical Association, 72 App. D. C. 12, 20, 110 F. (2d) 703, 711, *cert. denied,* 310 U. S. 644.

d methods
American
edly made
ot to legis-
pply stand-
Congress
otherwise
s to insist
vent, there
commerce,
necessary,
or profit.[16]
ssociation
ommercial-
s of Group
ade within
. The ac-
lay execu-
he profes-
ot tend to
nceded the
ns, to their
ngruity in
or a non-
reason for
nercial ac-
standards
mployer.[19]
undoubt-
y expense

poses charitable hospitals are not engaged in trade, business or industry,[21] we have no doubt that the hospitals described in the indictment were engaged in trade and commerce within the meaning of the common law and of the Sherman Act.[22]

So far as Group Health and the hospitals are concerned, therefore, their activities are properly described as business and commercial in character. There is also no question that commercial and business competition was not only the possible but the probable result of Group Health's activities. Consequently—entirely apart from any direct restraint upon the practice of medicine itself—if a conspiracy was shown, the purpose of which was to restrain competition, raise prices, or otherwise control the market to the detriment of purchasers or consumers of medical or hospital services, by destroying or injuring Group Health Association, it was sufficient to sustain the conviction.

The fact of commercial and business competition is the predominant note in the controversy which preceded the initiation of criminal prosecutions in this case.[23]

---

[21] Private hospitals, supported by appropriations and charity, held not an industry, and its employees not engaged in "industry, trade, craft or occupation" within the meaning of Anti-Injunction Act. Western Pennsylvania Hospital v. Lichliter, 340 Pa. 382, 387, 17 A. (2d) 206, 209. A charitable home for girls held not a "business, trade or industry" within legitimate operation of power to make city zoning laws. Rochester v. Rochester Girls' Home, 194 N. Y. S. 236, 237. A charitable home for the aged not a business within the sense of a restrictive covenant. Easterbrook v. Hebrew Ladies' Orphan Society, 85 Conn. 289, 298, 82 A. 561, 564; Note, 41 L. R. A. (N. S.) 615. A municipal ordinance declaring hospitals for profit to be nuisances does not discriminate in favor of charitable hospitals, as the distinction is reasonable. The former are and the latter are not "businesses." Lawrence v. Nissen, 173 N. C. 359, 364, 91 S. E. 1036, 1038.

[22] In Jordan v. Tashiro, 278 U. S. 123, 127–129, it was held that operation of a hospital was included within the meaning of the words "trade" and "commerce" as used in a treaty authorizing Japanese subjects in the United States "to carry on trade" and to "do anything incident to or necessary for trade upon the same terms as native citizens or subjects . . . " *Cf.* Lawrence v. Nissen, 173 N. C. 359, 364, 91 S. E. 1036, 1038: "The establishment and conduct of hospitals for pay is now a recognized and established business." In Armendarez v. Hotel Dieu, Tex. Civ. App., 145 S. W. 1030, 1031, it was held that in so far as a hospital accepted paying patients for the purpose of obtaining revenue to carry on its charitable work, it was carrying on a business.

[23] The identification of "fair competition" with ethical principles is expressed in the Principles of Medical Ethics of the American Medical Association and in the Constitution of the District Medical Society.

Chapter III, Article VI of the Principles of Medical Ethics reads in part as follows: "Conditions of Medical Practice. Section 2. It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. . . .

"Contract Practice. Section 3. ' . . . Contract practice per se is not unethical. However, certain features or conditions if present make a contract unethical, among which are: . . . 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community."

Chapter IX, Article III, Section 1 of the Constitution reads as follows: "It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient *or which interfere with reasonable competition among the physicians of a community.*" [Italics supplied.]

These provisions were utilized for purposes of disciplinary action against members of the District Medical Society employed by Group Health. Thus, the expulsion of Dr. Scandiffio, a member of the Group Health staff, from the District Medical Society followed a finding of the Compensation, Contract and Industrial Medicine Committee that he was guilty of violating Sections 1 and 2, Article III, and Section 5, Article IV, all of Chapter IX of the Constitution of the Society. That this disciplinary action against members of the Society was intended to affect Group Health Association is shown by the letter of December 10, 1937, sent by the Chairman of the Compensation, Contract and Industrial Medicine Committee of the Society to its Executive Committee which reads as follows: "On November 22nd, 1937, our committee addressed a communication to you advising you of our investigation concerning Drs. Allan E. Lee and M. Scandiffio and recommended that they be expelled as members of the Society because of their violation of Section 1, Article III, Chapter 9, and Section 5, Article IV, Chapter 9, of the Constitution of the Medical Society of the District of Columbia. Our committee is today in receipt of a letter from Dr. Allan E. Lee, advising us that he has resigned from the staff of Group Health Association. Inasmuch as our recommendation respecting Dr. Lee was based upon the fact that he had entered into a contract with Group Health Association and that contract has now been terminated by him, we feel that no further action should be taken with respect to Dr. Lee. We therefore, respectfully request that the charges and recommendations against Dr. Lee, embodied in our communication of November 22, 1937, be withdrawn and that appropriate action be taken by your committee thereon."

It is shown, also, by the letter of the same Chairman to Dr. Lee under date of December 21, 1937: "In acknowledgement of your letter of December 10, in which you enclose a copy of your resignation as a member of the medical staff of Group Health Association, Inc., may I say that upon receipt of same the Compensation, Contract and Industrial Medicine Committee appeared before the Executive Committee and requested a withdrawal of its charges against you, which request was granted. Such action places your status as that of a member now in good standing."

The concern of the defendants Association and Society with the effect of Group Health on the economic status of the medical profession, and upon competition in financing and

de *low-cost*
e the exist-
instruction
oup Health

articles and
urnal of the
s: "Out of a
employees of
ederal Home
n are eligible
allowing an
reached, out
on, according
e of medicine
reat through
e practice of
ical services,
eact against
ore liberally
f the poorest
ces rendered
the value of
ests that the
client or his
lical services
hose charged

s Director of
ciation from
ne. He was
r as follows:
ntial part of
ates Govern-
the District
e, would not
ice would be
sion."

Association with respect to low-cost medicine plans.[25] That appellants' attack on Group Health Association was designed to restrain competition is revealed by the following statement in their Reply Brief: "Appellants insist that the origin of GHA is traceable directly to the Twentieth Century Fund, its subsidiary corporations, and others whose purpose was to destroy the private practice of medicine in the District . . . and to establish corporate practice of medicine." If, as appellants thus contend, they believed that the purpose of the Twentieth Century Fund and the purpose of GHA was to destroy the private practice of medicine in the District, by establishing corporate practice of medicine, obviously, the bitterest kind of competition in making available medical and hospital service was under way. If the purpose of appellants was to prevent such competition by the destruction of GHA, obviously that purpose was to restrain trade.[26]

The important question is, therefore, whether the methods used constituted improper restraints of competition, within the meaning of the statute in the trade or commerce of financing and making available all or any of the three several services to which reference has been made. And, as the prosecution in the present case is under Section 3 of the Act no question of the interstate character of that trade or commerce is involved. Appellants urge a number of contentions to negate unlawful restraint. The first of these is that the controversy here involved is a labor dispute; hence that appellants are excluded from the operation of the Sherman Act, by virtue of provisions of the Clayton Act and of the Norris-LaGuardia Act.

Presumably appellants' contention casts medical doctors in the role of laborers; Group Health in the role of employer; and themselves in the role of labor organizations, or perhaps in a role comparable to that of the New Negro Alliance;[27] all this on the assumption that medical practice, the furnishing of medical services and the furnishing of hospital services, come within the common law definition of trade; with the consequence, they argue, that a controversy arising between these three groups, or any two of them, concerns "terms or conditions of employment, or * * * the association or representation of persons in negotiating, fixing, maintaining, changing, or seeking to arrange terms or conditions of employment, . . ."[28] That medical doctors, lawyers, teachers and other professional people can be and are *employed* there is no doubt. Some professional or pseudo-professional groups have organized themselves into unions. Medical societies and bar associations are sometimes referred to by laboring people as "doctors' unions" and "lawyers' unions." But after all it is a *labor dispute* which is the subject of definition and application in these Acts. Although, in the broader sense, all forms of mental and physical exertion may be called labor, even including attendance at a symphony concert or the labor of childbirth; and, although a dispute concerning any form of such labor might perhaps be called a labor dispute,

---

practitioners and specialists engaged in group practice under the sole direction of a medical director. Said corporation pays adequate salaries to the doctors on its medical staff and provides the medical staff with a modern, well equipped clinic, which was opened on November 1, 1937. Said corporation also defrays, within limits, the expenses of hospitalization of its members and their dependents. The personal relationship ordinarily existing between doctor and patient obtains between the doctors on the medical staff of Group Health Association, Inc. and their Group Health Association, Inc. patients."

[25] "Evidence has been permitted in this case with respect to the public need or lack of need of so-called low-cost medicine. I charge you that any need, or lack of need, for a low-cost medicine plan, has nothing to do with the right of the defendants to exercise their lawful powers and duties in connection with the practice of the medical profession. The rights of Group Health Association, Inc. are no greater because of an alleged need for low-cost medicine, than if no such need existed. Group Health Association, Inc. had a lawful right to disapprove of what it may have thought was the attitude of the defendants toward low-cost medicine plans, just as the defendants had an equal right to disapprove of what the defendants thought was the attitude of Group Health Association, Inc. with respect to low-cost medicine plans. Each party to the controversy had the right to further and advance its own opinion in the controversy by all methods of legitimate persuasion and reasoned argument whether applied to members of the medical profession, the Washington hospitals, or the public. Refused. J. M. P."

[26] That appellants' attack on Group Health was for the purpose of restraining competition is admitted, by implication, also in their opening brief: ". . . that a corporation known as the Twentieth Century Fund with assets of approximately $3,500,000, and whose main objective was to actively promote the organization of group payment agencies, i. e., organizations through which groups of people might obtain all-around medical and hospital care in return for some fixed periodic payments, was subsidizing GHA and enabling it to *sell medical services at less than cost* for the purpose of destroying the private practice of medicine and to set up in its place or stead a theory of the distribution of medical services advocated by such Fund; that HOLC was diverting Government moneys to subsidize GHA and thereby enabling it *to sell medical services at less than cost; . . .*" [Italics supplied]

[27] New Negro Alliance v. Sanifary Grocery Co., 303 U. S. 552.

[28] Norris-LaGuardia Act of March 23, 1932, 47 Stat. 73, 29 U. S. C. § 113 (c).

ed range of

ts indicate
n working-
ed capital,
rkman[33] or
tion is not

ationship,[36]
f employer
industrial
t, perhaps,
nd Clayton
ooperatives
norganized
and condi-
straint, or
would be
contracting
to render
eeded, they
endent con-
nsupervised

LaGuardia
esent case.
cularly sig-
riginal pur-

YALE L. J.

pose of the Clayton Act by infusing into it the *immunized trade union activities* as redefined by the later Act. In this light § 20 removes all *such allowable conduct* from the taint of being a 'violation of any law of the United States,' including the Sherman Law. * * * It was precisely in order to minimize the difficulties to which the general language of the Sherman Law in its application to *workers* had given rise, that Congress cut through all the tangled verbalisms and enumerated concretely the types of activities which had become *familiar incidents of union procedure*."[45] [Italics supplied] In the *Hutcheson* case the Court expressly distinguished the situation in which a union acts, not in its own self-interest, but in combination for other purposes, with nonlabor groups.[46] It cited as an example *United States* v. *Brims*.[47] In the latter case it was held that a conspiracy of manufacturers of millwork, building contractors and union carpenters, to check competition from nonunion made millwork was a violation of the Sherman Act; the conspiracy agreement being that the manufacturers and contractors would employ only union carpenters, who in turn would refuse to install the nonunion millwork. And, in contrast, the Court, in the *Hutcheson* case, also said: "Clearly, then, the facts here charged constitute lawful conduct under the Clayton Act unless the defendants cannot invoke that Act because *outsiders to the immediate dispute also shared in the conduct*."[48] [Italics supplied] This, it would seem, was also the situation in the *New Negro Alliance* case.[49] Assuming a *bona fide* labor dispute, the participation of a non-labor organization therein should not, without more, deprive it of its character as a labor dispute; give it the character of criminal conduct; or authorize judicial restraint except in compliance with the limitations of the Norris-LaGuardia Act.

But, under the circumstances of the present case, appellants cannot escape the proscriptions of the Sherman Act even if we assume that the controversy was a labor dispute. As we have already noticed, the Supreme Court plainly indicated in the *Apex* case[50] that some phases of labor disputes may come under the condemnation of the Sherman Act; if, for example, they involve a combination or conspiracy which has as its purpose restraint upon competition, or if the labor organization is used by combinations of those engaged in an industry as the means or instrument for suppressing competition or fixing prices.[51] In the *Apex* case the Sherman Act was held to be inapplicable because it did not appear that the strikers' acts were intended to restrain competition or that they had any effect on market prices of goods or services.[52] But that was not the situation of the present case.

Appellants reassert—in support of their contention that their conduct was not in restraint of trade—a proposition urged on the earlier appeal, that their conduct was no more than a reasonable regulation of the practice of medicine; and they rely upon the language of our earlier opinion: "If there is any justification for the restraint, so as to make it reasonable as a regulation of professional practice, it must be shown in evidence as a defense . . ."[53] But in that same opinion—after recognizing the large and beneficent part which appellants have played in raising the standards of medical practice, and in contributing to the relief of the unfortunate and destitute—we also said: "Notwithstanding these important considerations, it cannot be admitted that the medical profession may through its great medical societies, either by rule or disciplinary proceedings, legally effectuate restraints as far reaching as those now charged."[54] And we did not, by any means, declare the law to be—as appellants now assert—that a conspiracy "entered into with the object of properly and fairly regulating the practice of medicine, . . ." was not a violation of the Sherman Act. The prayer for instruction which appellants requested upon this point was contra-

---

[45] *Id.* at 236, 237.

[46] United States v. Hutcheson, 312 U. S. 219, 232.

[47] 272 U. S. 549.

[48] United States v. Hutcheson, 312 U. S. 219, 233.

[49] New Negro Alliance v. Sanitary Grocery Co., 303 U. S. 552, 555–556; Columbia River Packers Ass'n., Inc. v. Hinton, 315 U. S. 143.

[50] Apex Hosiery Co. v. Leader, 310 U. S. 469, 487–489.

[51] *Id.* at 501. See New Negro Alliance v. Sanitary Grocery Co., 303 U. S. 552, 562–563: " . . . short of fraud, breach of the peace, violence, or conduct otherwise unlawful. . . ."; United States v. Hutcheson, 312 U. S. 219, 231; "Therefore, whether trade union conduct constitutes a violation of the Sherman Law is to be determined only by reading the Sherman Law and § 20 of the Clayton Act and the Norris-LaGuardia Act as a harmonizing text of outlawry of labor conduct."

[52] Apex Hosiery Co. v. Leader, 310 U. S. 469, 501–502.

[53] United States v. American Medical Ass'n., 72 App. D. C. 12, 21, 110 F. (2d) 703, 712, *cert. denied,* 310 U. S. 644.

[54] *Ibid.*

could the
rofessional

o effect a
oposed in-
em powers
t of stand-
v. *Oregon*
n involved
e was up-
e power of

ht to con-
s in social
ps to make
ng profes-
or excuse
stitutions.
their pro-
on fee or
e salaried
anizations.
assistance
hly skilled
ation has
determina-
the main-
with acci-
legislation
rmal rules

Professions exist because the people believe they will be better served by licensing especially prepared experts to minister to their needs.[62] The licensed monopolies which professions enjoy constitute, in themselves, severe restraints upon competition. But they are restraints which depend upon capacity and training, not special privilege. Neither do they justify concerted criminal action to prevent the people from developing new methods of serving their needs. There is sufficient historical evidence of professional inadequacy to justify occasional popular protests.[63] The better educated laity of today question the adequacy of present-day medicine.[64] Their challenge finds support, as indicated in the margin, from substantial portions of the medical profession itself.[65] The people give the privilege of professional monopoly and the people may take it away. A highly regimented military profession under strict governmental control; a ministerial or religious profession, without uniform standards or licensure; a large group of highly trained persons who serve the people as experts in news collection and dissemination but who have never had professional standing, licensure or monopoly; [66] these are all examples of alternative methods which the people have used to develop and control their professional groups.

In some instances professional groups have been charged by legislative fiat with powers and duties concerning professional education, licensure, discipline, removal of licensees from practice, and other related subjects.[67] In such cases

---

[62] Alabama Power Co. v. Federal Power Commission, (No. 7853, decided March 30, 1942) — App. D. C. —, — F. (2d) —: "The grant of a license, being a privilege from the sovereign can be justified only on the theory of resulting benefit to the public. . . .' "

[63] SHRYOCK, THE DEVELOPMENT OF MODERN MEDICINE (1936) 2: "When Rush died, in 1813, he was widely acclaimed the greatest physician his country had known. Three short decades passed, and an outstanding American physician of the next generation found himself revaluing Rush's medical essays. The results were rather startling. 'It may be safely said,' observed Elisha Bartlett in 1843, 'that in the whole vast compass of medical literature, there cannot be found an equal number of pages containing a greater amount and variety of utter nonsense and unqualified absurdity. A more sudden and extreme revision of scientific opinion could hardly be imagined. Here was Rush lauded by one generation and repudiated by the next."

[64] SHRYOCK, *id.* at 371–372: "Hence there gradually evolved, in educated minds, a syllogism of some such form as this: Medical science can now prevent or cure certain major diseases. Many people continue to suffer from these very diseases. Ergo, medical science does not serve the people as it should. The most obvious explanation was to be found in the mounting costs of service. Here, again, it is to be noted that it was the very progress which physicians had made in science, which involved them in new difficulties in the practice of their art. Technical improvement led to simultaneous increase in the demand for medical services and in the price that must be paid for them. And so the more that people trusted medical aid, the less they could afford it. Here was a serious and unexpected impasse in the public relations of the profession."

[65] SHRYOCK, *id.* at 399–400: "In 1926 some fifteen leaders in medicine, public health, and the social sciences had inaugurated a series of conferences which led to the creation of a national Committee on the Costs of Medical Care. This body consisted of fifty members drawn from various interested groups ranging from private practitioners to economists. Dr. Ray Lyman Wilbur, Secretary of the Interior in President Hoover's cabinet, served as Chairman. . . . The Committee carried out a nation-wide survey of sickness and medical service among nearly nine thousand white families. Their reports revealed, by 1932, a direct correlation between income and all types of medical service; and tended in general to substantiate the claims made by the advocates of health insurance more than a decade before. The lowest income group (under $1,200 per year) received more of certain types of care—presumably due to charity services—than did the next two higher groups ($1.200 to $3.000); but in general these classes all received much less service than those whose incomes were above the last-named amount. Thus the group with the lowest amount of service received only 50 per cent as many days of hospitalization, and only 41 per cent as many medical calls as did the group with the highest amount of service. In every case, the latter was the highest income group. The highest group itself received less medical service than the standard which the majority of the Committee considered essential to good care."

The American Medical Association, it is true, disagrees with the conclusions of these eminent professionals. SHRYOCK, *id.* at 401: "Taking quite another view of the situation, the Bureau of Economics of the American Medical Association conducted an investigation which '. . . revealed the fact that there are few, if any, people in the United States really suffering from lack of medical care. . . .' "

[66] It is perhaps significant that in the latest professional development—radio broadcasting—increased emphasis has been placed on ruthless competition (Federal Communications Commission v. Sanders Brothers Radio Station, 309 U. S. 470) and governmental control. Federal Communications Act of 1934, 48 STAT. 1082–1087, 47 U. S. C. §§ 303(m), 304, 307(d), 309(b)(1), 311, 312(a)(b): *id.* 48 STAT. 1104, 47 U. S. C. §§ 606(c)(d), as amended by the Act of January 26, 1942, Public No. 413, 77th Cong., 2d Sess.

[67] *E. g.*, the Integrated Bar in the legal profession. The State Bar Act of South Dakota provides in part (South Dakota Laws 1931, c. 84, §§ 11, 13, 14 J. AM. JUD. SOC. 188, 189): "Section 11. Unlawful Practice of Law. After the organization of the State Bar has been accomplished, as provided by this act, the Supreme Court shall fix a date after which no person shall practice law in the State of South Dakota unless such person be a member of the State Bar in good standing. . . ."

"Section 13. Violation of Rules May Be Punished. The by-laws, rules and regulations, when adopted by the Bar Board and when approved by the Supreme Court, shall be binding upon all members of the State Bar, and the wilful violation of any such rules and regulations by any member of the State Bar may be punished by suspension from the practice of

s of power
vidence of
for which
nust abide
rivate cor-
ganize, to
self-disci-
h self-dis-
competing
nalogy of
ion in the
the Amer-
o destroy,
y lawyers,
tions and
ans of ac-
egislation,
the prac-
of legisla-
efined line
erman Act
have open
uasion and
corps, win-
But they
reasonable
ct.[71] This,
to extend
t may be
owers, but

pose is properly excluded.[73] Nor is the fact that a crime was committed with the intent to accomplish some ultimate good, an excuse for its commission;[74] even if it was for the purpose of enforcing the law.[75]

The same rule applies in conspiracy cases as in criminal cases generally. Thus it was no defense to a charge of conspiracy to dynamite a man's house that the house was a disreputable resort, a place where moonshine whisky was sold and where lewd women congregated for unlawful purposes.[76] And the same rule applies in cases of conspiracy under the Sherman Act.[77] Neither the fact that the conspiracy may be intended to promote the public welfare,[78] or that of the industry,[79] nor the fact that it is designed to eliminate unfair, fraudulent and unlawful practices,[80] is sufficient to avoid the penalties of the Sherman Act.

Appellants are not law enforcement agencies; they are charged with no duties of investigating or prosecuting, to say nothing of convicting and punishing. They have been given no power to require their members ,or Group Health Association, to reveal the intimate details of their affairs, as was attempted in the present case.[81] Except for their size, their prestige and their otherwise commendable activities, their conduct in the present case differs not at all from that of any other extra-governmental agency which assumes power to challenge alleged wrongdoing by taking the law into its own hands.[82] Although extreme situations may seem sometimes to have required vigilante action where effective law enforcement by duly constituted officers had broken down or never been established;[83] and although persons who reason superficially concerning such matters may find justification for extra-legal action to secure what seems to them desirable ends; this is not the American way of life.[84] If Group Health Association is illegal, or is engaged in illegal activities, there is a method provided by law to determine the facts and to secure appropriate action.[85] If further controls are needed in ate one to

---

[73] Republica v. Caldwell, 1 Dall. [Pa.] 150.

[74] People ex rel. Hegeman v. Corrigan, 195 N. Y. 1, 13, 87 N. E. 792, 796: "So, ordinarily, a criminal intent is an intent to do knowingly and willfully that which is condemned as wrong by the law and common morality of the country, and if such an intent exists, it is neither justification nor excuse that the actor intended by its commission to accomplish some ultimate good. 1 Bishop's Crim. Law, § 341. . . . One may not commit a crime because he hopes or expects that good will come of it. It is no defense to a charge of intentionally committing an act prohibited by law even that the dictates of his religious belief require one to do the act."; Reynolds v. United States, 98 U. S. 145.

[75] Crawford v. Ferguson, 5 Okla. Cr. 377, 115 P. 278, 279–280: "A violation of law, when committed even for the purpose of enforcing the law, is not only illegal, but it is anarchy itself."; Hamp v. State, 19 Wyo. 377, 406, 118 P. 653, 662; Charge to the Grand Jury, Quincy [Mass.] 218, 221: "Levying War against the King is High Treason; as where People set about redressing public Wrongs; this, Gentlemen, the Law calls levying War against the King; because it is going in direct Opposition to the King's Authority, who is the Redresser of all Wrongs."

[76] Nails v. Commonwealth, 228 Ky. 838, 16 S. W. (2d) 474.

[77] Sugar Institute, Inc. v. United States, 297 U. S. 533, 599: "The freedom of concerted action to improve conditions has an obvious limitation. Then end does not justify illegal means. The endeavor to put a stop to illicit practices must not itself become illicit. As the statute draws the line at unreasonable restraints, a cooperative endeavor which transgresses that line cannot justify itself by pointing to evils afflicting the industry or to a laudable purpose to remove them."; Paramount Famous Lasky Corp. v. United States, 282 U. S. 30, 44.

[78] Eastern States Retail Lumber Dealers' Ass'n. v. United States, 234 U. S. 600, 613.

[79] Paramount Famous Lasky Corp. v. United States, 282 U. S. 30, 43; United States v. First National Pictures, Inc., 282 U. S. 44.

[80] Fashion Originators' Guild of Ameica, Inc. v. Federal Trade Commission, 312 U. S. 457, 468.

[81] United States v. American Linseed Oil Co., 262 U. S. 371, 389.

[82] Fashion Originators' Guild of America, Inc. v. Federal Trade Commission, 312 U. S. 457, 465–466: "In addition to all this, the combination is in reality an extra-governmental agency, which prescribes rules for the regulation and restraint of interstate commerce, and provides extra-judicial tribunals for determination and punishment of violations, and thus 'trenches upon the power of the national legislature and violates the statute.' *Addyston Pipe & Steel Co.* v. *United States*, 175 U. S. 211, 242."

[83] 23 Encyc. Brit. 146. See Denver and Rio Grande Ry. v. Harris, 122 U. S. 597, 606; Boyle v. Case, D. Ore., 18 F. 880, 883–885; Sanders v. Gilbert, 156 N. C. 463, 481, 72 S. E. 610, 617.

[84] Charles Evans Hughes, 18 Proc. of Am. Law Inst. (1941) 24, 29: "Democracy cannot escape its pressure groups. Each interest has its imperious demands. These groups compete in the market place, in the forums of public opinion, in popular elections, and in our legislative halls, but they have no place in the halls of judicial administration. The lamps of justice are dimmed or have wholly gone out in many parts of the earth, but these lights are still shining brightly here. We are engaged in harnessing our national power for the defense of our way of life. But that way is worthwhile only because it is the pathway of the just. It is our high privilege, although out task may seem prosaic, to strengthen the defenses of democracy by commending to public confidence and esteem the working of the institutions of justice in both state and nation."; Note, 2 Geo. Wash. L. Rev. 498.

[85] D. C. Code (1940) §§ 2–101, 2–102, 2–132, 2–137, 29–719, 29–725, 35–1347. Proceedings instituted by Group Health Association has established that its activities do not violate the insurance laws of the District of Columbia. Jordan v. Group Health Ass'n.,

period of
ed various
cians' con-
r medical
ackground
l Associa-
in detail
sought to
consistent
cy of dis-
true that
hough the
in general
ere objects
that these
e attitude
nissible as
ch are the
may have
nd that it
appellants

d a finding
the District
This part
. C. 38, 39,

a plan pro-sought only to exclude it entirely, rather than merely to limit its phobative force, there was, consequently, no error in admitting it,[89] in any event.

Appellants contend further, in this connection, that: "A misdemeanor such as described in Section 3 of the Sherman Act is not a violation of the law in Texas, Wisconsin, or any other state of the United States. A restraint of intrastate trade in Texas or Wisconsin is not a violation of any law of the United States, and so far as this record discloses, of any state law. Every man has a right to do it, and no finger of scorn is to be pointed at him for doing it. To permit the Government to prove in a case pending in the District of Columbia lawful acts that were performed by the defendant AMA in Texas and Wisconsin is error." But as applied to the present case the premise is incorrect and the conclusion does not follow. In the first place, it is elementary that if the object of a conspiracy is criminal, then evidence of conduct—otherwise lawful—but which is intended to achieve that criminal objective may properly be received to prove the conspiracy.[90] In the second place, whether the particular conduct was criminal at the time and place where it occurred is beside the point. Evidence has been admitted to prove background, even though it concerned conduct which occurred prior to adoption of the act under which the indictment was found;[91] as well as concerning conduct which occurred before the date in the indictment when it was alleged that the accused persons conspired.[92] The disputed evidence in the present case was not offered to prove the commission of crimes in Texas, Wisconsin, or other states, but to prove the commission of a crime in the District of Columbia, by proving the background of appellant's conduct in the Distric tof Columbia. What it did in the District was part of a larger plan. Evidence of conduct in other states—which may have been perfectly lawful according to the laws in force in those states—was nevertheless proof of appellant's intent and purpose in acting as it did in the District.[93] The cases relied upon by appellants require no other conclusion. One of them is not in point and in both of the others all the acts complained of were committed outside the United States.[94] In *Eastern States Petroleum Co., Inc.* v. *Asiatic Petroleum Corp.*, Judge Chase, speaking for the Second Circuit Court of Appeals, put the case in a nutshell when he said: "Likewise, what was done wholly abroad *unaided by acts in this country* must be counted out."[95] [Italics supplied]

Appellants contend that the verdict of the jury acquitting all the defendants except the American Medical Association and the Medical Society of the District of Columbia, and convicting the two latter associations, constitutes such inconsistency as to require that the verdicts of guilty be set aside. It has been held many times that inconsistency in verdicts does not require the result contended for by appellants.[96] And this is true even though the inconsistency can be explained by no rational considerations.[97] The question for us is whether the conviction is consistent with the evidence.[98] Complete identity of participation in the conspiracy was not necessary upon the part of the participants, either in fact or in law. While such complete identity is not necessary in order to sustain a

---

[89] Greater New York Live Poultry Chamber of Commerce v. United States, 2 Cir., 47 F. (2d) 156, 159, *cert. denied,* 283 U. S. 837.

[90] Aiken v. Wisconsin, 195 U. S. 194, 206; Swift and Co. v. United States, 196 U. S. 375, 396; Badders v. United States, 240 U. S. 391, 394; Duplex Printing Press Co. v. Deering, 254 U. S. 443, 465; Falstaff Brewing Corp. v. Iowa Fruit & Produce Co., 8 Cir., 112 F. (2d) 101, 108; Lynch v. Magnavox Co., 9 Cir., 94 F. (2d) 883, 889; Marino v. United States, 9 Cir., 91 F. (2d) 691, 694, *cert. denied,* 302 U. S. 764.

[91] Standard Oil Co. v. United States, 221 U. S. 1, 46–47: ". . . . it tended to throw light upon the acts done after the passage of the Anti-trust Act and the results of which it was charged were being participated in and enjoyed by the alleged combination at the time of the filing of the bill."

[92] Heike v. United States, 227 U. S. 131, 145: "The longer it had lasted the greater the probability that he knew of it and that his acts that helped it were done with knowledge of their effect."; Baush Machine Tool Co. v. Aluminum Co. of America, 2 Cir., 72 F. (2d) 236, 239, *cert. denied,* 293 U. S. 589; Wilson v. United States, 6 Cir., 109 F. (2d) 895.

[93] See Greater New York Live Poultry Chamber of Commerce v. United States, 2 Cir., 47 F. (2d) 156, 159, *cert. denied,* 283 U. S. 837.

[94] American Banana Co. v. United Fruit Co., 213 U. S. 347, 357; Eastern States Petroleum Co., Inc. v. Asiatic Petroleum Corp., 2 Cir., 103 F. (2d) 315, 319.

[95] *Ibid.*

[96] United States v. General Motors Corp., 7 Cir., 121 F. (2d) 376, 411, *cert. denied,* 314 U. S. 618; Bryant v. United States, 5 Cir., 120 F. (2d) 483, 485; Dunn v. United States, 284 U. S. 390, 393; Steckler v. United States, 2 Cir., 7 F. (2d) 59, 60; United States v. Austin-Bagley Corp., 2 Cir., 31 F. (2d) 229, 233, *cert. denied,* 279 U. S. 863; Crichton v. United States, 67 App. D. C. 300, 303, 92 F. (2d) 224, 227, *cert. denied,* 302 U. S. 702. See United States v. Bergdoll, E. D. Pa., 272 F. 498, 505, *cert. denied,* 59 U. S. 585.

[97] United States v. Austin-Bagley Corp., 2 Cir., 31 F. (2d) 229, 233, *cert. denied,* 279 U. S. 863.

[98] United States v. General Motors Corp., 7 Cir., 121 F. (2d) 376, 411, *cert. denied,* 314 U. S. 618.

be enough
nd others
aid: "The
author of
said that
that the
recruiting
ng was on
therefore
e statute,
t shall be
nt service
rite these
ent service
print and
ent. This
t we have

dual crim-
corporate
The fact
v separate
e criminal
und guilty
t.[103] This
been held
ler to find
[105] In the
; some of
s the two

the problems which confront us in the field of national health. In many respects, however, they are not comparable. S. 1320 provides for a comprehensive program which embraces five of the six points the Public Health Service has advocated as the components of an effective national-health program: Expansion of public-health services and organizations; construction of needed hospitals and related facilities; education of professional personnel; extension of scientific research; and implementation of a medical-care program. The sixth area of national-health need which S. 1320 does not cover specifically is that of environmental sanitation.

S. 545, on the other hand, does not purport to authorize a comprehensive program. Rather, it addresses itself primarily to one specific area of need—to medical care. To be sure, it contains some provisions for cancer control, for dental care, and for dental research. But the bill basically is directed toward the problem of obtaining personal health services for the medically needy.

In short, S. 1320 would attack the weakness in our National health structure on a broad front. S. 545 proposes an experimental program, aimed essentially at one basic need.

With the committee's permision, I shall limit my remarks to the general features of the two bills, leaving detailed comments to any discussion which may follow at the conclusion of my statement.

It is only in the approach to the problem of medical care that we can contrast the provisions of S. 1320 and S. 545. The former bill would establish a national system of compulsory health insurance to finance comprehensive medical services for approximately 85 percent of the population, through pay-roll deductions, supplemented by general taxation. Administration would be decentralized to a considerable extent to State and local governments.

S. 545, on the other hand, is designed to make available general health, hospital, and medical services to families of low income. Health- and dental-inspection services would be provided to all school children. States also would be assisted in making available dental care for school children and for individuals and families who are unable to pay the whole cost of such care. The program would be financed jointly by the Federal Government and the States on a matching basis.

In testimony submitted before the Seventy-ninth Congress the Public Health Service stated the belief that the health needs of the Nation could be met most effectively and in the shortest period of time through a broad program financed in part through health insurance. This position was based not on a preference for any particular scheme or social organization or pattern of Government action but rather on the conviction that such an approach will bring us more quickly to our health goals than any plan yet suggested.

From our viewpoint the most significant feature of S. 1320 is that it would definitely commit the Federal Government, in cooperation with the States, to a concerted attack on the problem of providing adequate medical care for all our people.

The Public Health Service fully recognizes that neither S. 1320 nor any other legislation of itself could immediately provide adequate medical care for the entire population. There obviously will be some time lag between the inauguration of the program and the develop-ome the

ould we
t's if the
d deduc-
y would

n. I am
ire some
ome.
national
s as well

title III,
and the
alization
n a date
effective.
was the
am.
v on the
anything

An unwilling medical professional would present the greatest obstacle.

Senator SMITH. I notice that, and it troubles me at the moment because we know the medical profession is apparently very unwilling to go along with a program of this kind at this time. All the doctors I have talked to feel it should be done by the trial and error method rather than by an over-all program. If they resist it, I do not see how you are going to develop your plan without some attempted method of compulsion.

Dr. PARRAN. The Public Health Service realizes that the issues involved in these bills go far beyond administrative difficulties and beyond methods of financing. They include fundamental questions relating to the political and economic foundations of our national-health structure which are matters of public policy and which only the Congress can resolve.

The testimony of the Public Health Service and of many other witnesses presented before the committee during hearings on the national-health bill of 1945 dealt largely with compulsory health insurance.

In addition, the Administrator of the Federal Security Agency in his statement gave particular attention to the compulsory health insurance approach as embodied in S. 1320. I should like, therefore, to deal largely with an alternative approach—the more limited developmental program.

Senator DONNELL. Have you read the statement of Mr. Watson B. Miller?

Dr. PARRAN. Yes, sir.

Senator DONNELL. Did you hear him testify?

Dr. PARRAN. I did.

The history of health legislation and service in the Federal Government has been characterized by the selective approach to particularly urgent problems. While this process has resulted in some unevenness in development and some difficulty in administration, the record clearly shows substantial progress through this approach. In fact, the present program of the Public Health Service has been along these very lines.

Our earlier efforts were directed toward the conquest of diseases amenable to mass controls—smallpox, typhoid fever, pellagra, and the like. Later, we have sought to control specific diseases of public-health importance, venereal diseases, tuberculosis, mental disease, and cancer.

Senator SMITH. You are speaking of the field of preventive medicine, smallpox vaccination, typhoid fever, pellagra, and the like.

Dr. PARRAN. Yes; that is correct. And in the case of venereal diseases, tuberculosis, mental diseases, and cancer, the present Public Health Service program goes beyond prevention—to supervision and treatment of the individual.

In the case of venereal disease and tuberculosis, it is obvious that an infected individual is a hazard to his fellowman.

In diseases such as mental diseases and cancer, it is obvious that they require a totally different kind of treatment.

In approaching one after another health problem of the Nation, first efforts obviously should be directed toward the sectors of greatest need. The Public Health Service, after years of study, has defined six elements of a national-health program. A brief review of steps toward those six goals may be helpful in identifying our present position and in charting a future course.

services
cularly to
the Vene-
he Public
rovisions,
and Con-
nced the

rengthen-
al health
l. Over
most of
lic health

f deaths
ventable.
t burden
e fit race,
out these
and even
deterrent
alth and

current shortages will become progressively more acute. These estimates are based upon present demands and do not take into consideration the added service which would be required by either S. 545 or S. 1320.

4. EXTENSION OF RESEARCH

In the field of research there has been considerable progress in recent years. Enactment of Public Law 410 by the Seventy-eighth Congress gave to the Public Health Service broad authority for research into the prevention, cause, and cure of the diseases of man. This legislation has been strengthened by the research provisions in regard to mental health and cancer control. With the additional legislation now pending before Congress, especially the bill to establish a National Science Foundation, the Federal Government will have created an adequate statutory basis for a strong, integrated program of research within and outside of Government which is essential to the advancement of national health.

5. ENVIRONMENTAL SANITATION

While great advances have been made in recent decades toward overcoming environmental health hazards, we are still far from the goal of providing a sanitary environment for all our people. One major sanitation hazard in early need of attention is the extent of pollution of our streams and waterways. Legislation sponsored by Senators Taft and Barkley and comparable bills in the House directed toward this specific problem is now being considered by the Congress. A further extension of Federal aid as contemplated by these bills is necessary if we are to round out this important element of our national health program.

6. IMPLEMENTATION OF A MEDICAL-CARE PROGRAM

Over many years, governments have assumed increasing responsibility for providing medical care for specific diseases and for specific groups within the population. Since Elizabethan times, Anglo-Saxon societies have accepted some degree of responsibility for the sick poor. In more recent years, care of the mentally ill and of the tuberculous has been recognized as a public function. Diagnosis and treatment for venereal disease is now offered in programs operated cooperatively by the Federal and State Governments. In addition, medical care is provided veterans and other categories of Federal beneficiaries at Federal expense.

Except for such groups, however, there is as yet no Nation-wide program to aid in providing adequate personal health services. This is a conspicuous weakness in our total health program. There is general agreement that a solution to this problem is fundamental to the health of the Nation. There is similar agreement that the cost of adequate medical care is beyond the means of a large proportion of the sick and disabled.

This brief review of our present situation, I believe, highlights three areas of urgent need: First, there is a lack of public health services in many parts of the country and particularly in our rural regions; second, there are not enough physicians, dentists, nurses,

rt of our
The Con-
y to these

templated
ong local
l curative
between
ealth per-
care, we
re.
I believe

ery com-
nounts of
ortion to
attern of
ed. The
und basis.
ic health
f section
lines in-

training

If the Congress elects initially to provide only a limited approach to a medical-care program, most of the concepts of title II of S. 545, which would create a new title VII in the Public Health Service Act, seem to me to be sound, with some modifications which I shall specify.

State surveys as contemplated in S. 545 obviously are necessary. Their usefulness would be enhanced, if they were to include the three areas in which I have recommended simultaneous action and if they were directed also toward the determination on a State basis of the relative urgency of need.

A limited program should attempt to meet first needs first. In some cases, incomes may not be the most reliable index of urgent need. There are many areas in our country, particularly rural areas, where few, regardless of incomes, have ready access to adequate medical care. Likewise in some serious illnesses, including the chronic diseases, the cost of adequate care is prohibitive even to persons in the middle- or higher-income brackets. Also, the most effective way to attack our dental health problem may be to concentrate on dental care for children. In this case, age provides a better index of priority than income.

Any Federal legislation should make it clear that each State would be permitted to develop a health program more comprehensive than the minimum required and to operate it in a single administrative pattern, using its share of the Federal grant in any appropriate way. Obviously, it would add to the complexity and cost of administration to have one program for persons of low income and another for other persons.

S. 545 very wisely assigns primary responsibility for the administration of the program to the State and local governments. As I have already indicated, I believe that Federal legislation should give the States even wider latitude on program content, subject to minimum Federal standards. I agree with the New York Academy of Medicine that enabling legislation should clearly authorize and promote the provision of comprehensive, as opposed to limited, medical-care services.

The authors of S. 545 have repeatedly emphasized that one of its principal objectives is to establish 48 "State laboratories" for practical experimentation in new and improved methods of providing or assuring medical-care services to all our people. I should like to suggest three important areas of fruitful exploration:

(1) Further experimentation is needed in new and improved methods of making high-quality medical care available in a more efficient and economical manner. I should like to endorse the emphasis which the New York Academy of Medicine has placed on the organization of group practice and special diagnostic centers. This was one of the two principal recommendations of the Committee on the Costs of Medical Care, under the chairmanship of Dr. Ray Lyman Wilbur, distinguished Secretary of the Interior under President Hoover, past president of the American Medical Association, and chancelor of Leland Stanford University. The other was for voluntary health insurance.

Senator DONNELL. May I interrupt there?

Dr. PARRAN. Yes, sir.

Senator DONNELL. You say this:

> I should like to endorse the emphasis which the New York Academy of Medicine has placed on the organization of group practice and special diagnostic centers.

age 11 of
Academy

. Wilbur.
ttee when

erson who
all need a
f both.
ess to de-
d medical
stated.
voluntary

hield.
ng is they

Chairman,
ition, en-

Congress

es of med-
ration of

health of the family, that we seek to conserve. Integration of preventive and curative health services, therefore, is essential. While S. 545 conforms to this principle in requiring unified administration of all State health programs, it appears to violate the principle in its provisions relating to Federal administration. I am in agreement with the points of view expressed in this connection by the Association of State and Territorial Health Officers, the American Public Health Association, and the New York Academy of Medicine.

In its present form, S. 545 would allocate administrative responsibility for the direction of the new programs of medical, hospital, and dental care services to separate units of a new agency. These provisions would permit, if not actually create, a dangerous schism within our Federal health structure. The scientific statutory authority vested in the directors of the several new offices, as contrasted with the very general definition of the Administrator's functions, invites separate and uncoordinated administration. The specification of the several component units of the agency dealing with related aspects of health would have the effect of reducing the functions of the Public Health Service substantially to quarantine and preventive health work. Moreover, S. 545 in its present form would tend to complicate and confuse well established Federal-State relationships.

Senator Smith. Let me pause there. I gather from that statement you do not think that in terms of over-all health the Public Health Service has a special function. What would you think the Public Health Service would be over-all?

I am not quite clear as to what you visualize as the goal. I may say we had the testimony of Mr. Miller this morning.

I would appreciate your comment as to the best administrative way of dealing with health.

Dr. Parran. Mr. Chairman, I hope ultimately to see a Department of Health under a departmental officer.

Senator Smith. Do you mean to say you would rather see an Under Secretary of Health?

Dr. Parran. No. Ultimately I hope to see a Department of Health under the direction of a Cabinet officer. Since that time seems remote, my next preference is for health to be included in a combined Cabinet department embracing also education, social security, and related functions, as provided by S. 140. Even this well-intentioned bill should be modified so that the three Under Secretaries would serve as general assistants to the Secretary, rather than as heads of operating bureaus, as the bill seems to contemplate.

Senator Donnell. You say ultimately you hope to see a Department of Health under the direction of a Cabinet officer.

Dr. Parran. That would be my view.

Senator Donnell. Would you favor a Cabinet officer who would have as his sole duty the operation of the Department of Health? Is that right?

Dr. Parran. I would ask, Senator Donnell, that you either refer to my statement on page 14, or permit me to repeat it, because I cannot answer "Yes" to your question.

Senator Donnell. The only reason I asked is, you say "ultimately I hope to see a Department of Health under the direction of a Cabinet officer."

complete

f Health
?

sition on
f Health.
e pattern
ept clear
partment

partment
Welfare,
er a head
y. Have

to be the
l have as
Is that

t. They
am pro-

proportion of the best minds from each of the health professions. This is not now the case.

Ambitious national health programs—such as these being considered by this subcommittee—no matter how wisely the law be drawn, will fail unless additional competent minds can be induced to aid in the tasks of administration and research.

In all seriousness, I will say that unless substantial financial relief is given promptly to our present health personnel, our present health laws, excellent though they be—yet limited as compared with those you are considering—may profit us nothing.

Senator SMITH. Dr. Parran, S. 545 provides for $200,000,000 a year.

Everybody knows $200,000,000 a year could not cover the entire health needs of 140,000,000 people.

Would you not say it were more desirable to get an appropriation of that kind because of the matching features? Would it not be desirable to move at least in that direction today toward these objectives you have in mind?

Dr. PARRAN. Mr. Chairman, I have been engaged in public-health work for a long time, and there was a time when the proposal of $200,000,000 appropriation would have seemed like the millenium.

I believe any funds should be spent under laws wisely drawn, which do not create obstacles to later expansion in the interests of advancing national health.

I would emphasize the necessity for moving in three ways all together at the same time: Preventive medicine, training of personnel, and medical care.

Senator SMITH. I want to apologize to you for having held you over until this afternoon, but you were here this morning and you saw the reason for the delay.

Senator Donnell, have you any questions?

Senator DONNELL. Dr. Parran, in S. 1320 there is a considerable portion of that bill devoted to details having to do with decentralization, State functions, et cetera.

I call to your attention the provision at the bottom of page 39:

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

And, also:

> The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

By "the title" I am referring to title II, which is prepaid personal health-service benefits, which I take it is the compulsory health-insurance feature of the bill.

You have studied that bill in detail.

Dr. PARRAN. I have tried to study it, but I cannot qualify as an expert.

Senator DONNELL. Is there any provision you know of anywhere in the bill that would take away from the Federal Security Administrator this direction and supervision over the national-health insurance, or take away from that Board the power to perform such functions as it finds necessary to carry out the provisions of the compulsory health-insurance title?

fore, if I
will for-

urity Ad-

ther with
with the
shall con-
President
thers who
e and the

curity are
the three
confirmed

der these
ne regula-

that the

naving an

changed so that the power to make those regulations should be in the Board rather than the Federal Security Administrator?

Dr. PARRAN. That is my best judgment; yes.

Senator DONNELL. It would appear you answered my first question when you said the making of regulations is a function of the Board? I think that is the language I have quoted.

Dr. PARRAN. Yes. Senator Donnell, may I say I had responded only fractionally to the very important question you interposed.

Senator DONNELL. Yes.

Dr. PARRAN. And I would like——

Senator DONNELL. Would you like to respond fully?

Dr. PARRAN. Yes. I think your question was directed to the fact whether the responsibility——

Senator DONNELL. Yes.

Dr. PARRAN. I pointed out——

Senator DONNELL. That is with respect to regulations?

Dr. PARRAN. It is.

Senator DONNELL. Very well.

Dr. PARRAN. I should like to point out some other respects in which the provisions of the bill deprive the Federal Security Administrator of much power.

Any State wishing to do so may assume responsibility for the administration of the benefits in the State by submitting a plan which complies with the conditions set forth in section 242 of the bill. The requirements in S. 1320 that States submitting personal health service benefit plans must be permitted to administer the program constitutes a major difference in this respect between S. 1320 and its predecessor, S. 1606, since under S. 1606 the Federal Security Administrator could utilize State and local agencies, but only to the extent the local agency saw fit.

I say parenthetically the principle endorsed by Senator Murray and his colleagues for administration by the Board is much more sound than the provisions of S. 1606, which would vest much of that authority in the Surgeon General alone.

Once a State plan has been approved, the State assumes full responsibility and authority to administer benefits in the State, including such functions as:

1. Medical services, hospital services, and State resources available under section 202 (a) and section 242 (a).

2. Maintaining necessary contractual and other relationships with doctors, dentists, nursing services, hospitals, and other persons and organizations who furnish benefits under the act, or who represent such persons, including:

(*a*) Passing upon their qualifications to furnish benefits (secs. 211 and 216);

(*b*) Negotiating terms and conditions of agreement for furnishing of health service, such as method of payment for such services (sec. 218); amount of fees and their payment (sec. 219); type or types of service to be furnished; the patients to be served; the records to be kept; the reports to me made, et cetera;

(*c*) Negotiating or entering into agreements with such persons directly or through their duly authorized representatives (secs. 215 and 216);

l pay the

ng oppor-
ements or
and 262).
ssure that
s needed,
ppeal ma-
l review,

shortages
5).
employees
and pro-
allocating
he admin-
the State

ferring to
available
practices,
provided
shall be
ive com-

At the time this bill was first filed, it was publicly stated that we didn't regard it as the final answer, and that we expected as a result of extensive hearings, there would be opportunity to improve it.

Senator DONNELL. Doctor, I call to your attention the contents of a portion of page 34.

Dr. PARRAN. Senator Donnell, there has just been handed to me across the press table a further answer to your earlier question, which I was not able to answer.

Senator DONNELL. Very well.

Dr. PARRAN. It is required on page 33, line 19, as one of the requirements of the State plan that the State plan shall provide for the decentralized administration of this title in the State in accordance with part C for the designation of local health-service areas, and so forth. In other words, I was not able to say who determines "as fully as practicable." It would seem in the light of what has been drawn to my attention that the State plan should be considered in relation to the language which you quoted on page 25, line 2, "fully as practicable."

Senator DONNELL. I don't think the conclusion you draw is justified for the reason that subdivision 3 on page 33 says nothing more than that the State plan of operation shall provide for decentralized administration of this in accordance with part C, and that is the section from which I read, which does not say who makes the determination of what is "as fully as practicable."

So, I think subdivision 3—very respectfully I suggest to you—on page 33 does not answer the question.

Dr. PARRAN. Undoubtedly we are wasting your time to debate the legal point.

Senator DONNELL. No, sir; I am asking these questions on the theory that your answers should be helpful, and I am sure they are.

Now, doctor, in this connection, however, I call to your attention, and I was just about to do this before you called to my attention this matter, the immediately succeeding subparagraph on page 34. There is a description of the State plan of operation. As you will recall, section 242 (a) says that any State desiring to assume responsibility, and so forth, may do so for a period prescribed in (c) if it is undertaken to administer the benefits and had approved a State plan of operation, and then subdivision 4 on page 34 provides such methods of administration, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Board shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Board to be necessary for the proper and efficient administration of such benefits in the State.

Obviously, I take it that you and I would agree that there is left to the Board, which in turn according to page 39, administers all of its functions under the direction and supervision of the Federal Security Administrator, the power to determine what methods of administration, including methods relating to the establishment and maintenance of personnel standards on a merit basis are necessary for the proper and efficient administration of the benefits in the States.

reafter in
is true,

elieve the
Act and
agues can

it system
ofessional
eration in
to me to
in health

s to your
, this sec-
only one
provided
ethods of
ment and
h respect
?—by the
nistration

Senator DONNELL. Regardless of that, Doctor, that is what the bill says.

Dr. PARRAN. You have read the language of the bill. I have one interpretation of the authority of the Board versus the authority of the Administrator, and you have another.

Senator DONNELL. Very well. In your statement at page 4 I observe a transition to an entirely different subject. You point out on page 4 that the Administrator of the Federal Security Agency in his statement, which was given this morning, gave particular attention to the compulsory health insurance approach, and then you say that you would like, therefore, to deal largely with an alternative approach, the more limited developmental program, which leads me to ask, Doctor, whether or not you have over a period of years expressed yourself as being favorable to compulsory national health insurance.

Dr. PARRAN. The Public Health Service is on record favoring compulsory national health insurance.

Senator DONNELL. Are you personally on record to that effect?

Dr. PARRAN. I am trying to recall, Senator. Perhaps I can answer your question and I shall try to be brief. I think we make too much of certain words, which have become fighting words, like "compulsory" versus "voluntary" or "health insurance" versus "taxation." Insurance if it is compulsory, is a tax. Every tax we pay is insurance, and so we are dealing with semantics in a way.

Also, while emphasis has been placed upon the voluntary nature of S. 545, I would point out that the Congress might provide sufficient inducements, levy general taxes to such an extent that no citizen except the most wealthy could afford to stay uninsured, and thereby by indirection through the power of taxation and yet under the guise of a voluntary system would create a compulsory system.

In some of the Scandinavian countries the practical result is that most all of the population is insured because the inducement is so great that nobody can afford to stay out of the system.

Now, I am trying to respond further.

Senator DONNELL. Go ahead.

Dr. PARRAN. I do not feel prepared to have a personal opinion as to whether it is more convenient for the Congress to exercise its taxing power in terms of a pay roll deduction or an earmarked income tax. It is a matter quite beyond my competence. I believe and I have striven to state in my testimony that I think there should be no property qualifications for health, that we should as rapidly as possible strive toward the goal, which cannot be reached tomorrow or perhaps even in a decade, of providing an equal opportunity for health for all of our people.

Senator DONNELL. Doctor, you addressed the Jackson County Medical Society in Kansas City, Mo., some years ago, did you not?

Dr. PARRAN. I recall that very pleasantly.

Senator DONNELL. That was August 20, 1943?

Dr. PARRAN. Thank you for refreshing my mind as to the date.

Senator DONNELL. It was at a luncheon at the Hotel Muehlbach?

Dr. PARRAN. Yes.

Senator DONNELL. At that time did you discuss the Wagner-Murray-Dingell bill?

inly dis-
ave cate-

Jackson
prepara-
he fram-

s Senator

your em-
n as sani-
f threats
ubject of
e?

ed to at-
y and of
s for the
or, in my
ment this
nore com-
ns to me

Dr. Parran. I made an address in 1939, and I assume you have quoted the date correctly.

Senator Donnell. Did you at that time make this statement?

> The national health program wisely leaves to the States the decision as to whether or not health insurance, either voluntary or compulsory, should be adopted in any State.

Dr. Parran. May I see your reference, sir? I am afraid I have made too many speeches to remember the exact texts of all. I hope they are not too inconsistent. This seems to be my language, and the leading sentence is as follows:

> We must all concern ourselves actively to provide more and better medical care for the needy. With equal zeal we must see to it that changes should not be made which may impede continuing progress in the medical sciences. Steps toward national health should seek not only to extend medical service but vastly to improve it, and at the same time to avoid any revolutionary change in our present form of medical practice.

Senator Donnell. That is August 26, 1939. A little further down on the page is this language, and I ask you again whether or not this was included in your address:

> The national health program wisely leaves to the States the decision as to whether or not health insurance, either voluntary or compulsory, should be adopted in any State.

Dr. Parran. Yes; I think in that connection I was referring to the original Wagner-Murray bill.

Senator Donnell. That is the bill S. 1620, introduced February 28, 1939. I assume you wouldn't remember that date, but I have the bill here, and that was the one pending at the time you delivered this address in California.

Doctor, did you make any other addresses since or before that time in which you expressed the same view that it is wise to leave to the States the decision as to whether or not health insurance, either voluntary or compulsory, should be adopted in any State?

Dr. Parran. I think I may have statements along that line about that time. Actually, I believe, and I hope you will agree, as I have tried to state in my earlier testimony, that the fundamental questions which you are considering here, Mr. Chairman and members of the committee, really go very deeply into our whole political and economic philosophy.

On that score I profess no competence. I have devoted myself to the technical and professional aspect of what broadly we call public health. In other words, it is a matter of congressional policy how the Congress decided in 1935, after very careful consideration, as I recall it, that certain parts of the Social Security Act should be federally administered, certain parts should be by way of grants to the States, and State systems set up. That is a matter which I think is in your competence, sir, and on which I would not hold any firm or authoritative opinion.

Senator Donnell. And, Doctor, you were a member, were you not, of the Interdepartmental Committee to Coordinate Health and Welfare Activities, supported by the President in August 1935, following the passage of the Social Security Act?

Dr. Parran. I was not appointed in 1935. I took my present position in April 1936, but I was a member of that committee in the late thirties.

pointed in
resident in

ou not?

in 1938;
l Care; is

at report?

hat in part
re for the

e programs
s.

aid to the
oups of the

jointly or

Dr. **Parran.** Yes.

Senator **Pepper.** What was the date of that?

Senator **Donnell.** 1938.

Dr. **Parran.** There were other recommendations in the report also.

Senator **Donnell.** I understand. But you concurred in that one?

Dr. **Parran.** Yes, sir.

Senator **Donnell.** I want to call to your attention, Doctor, the first Wagner bill. You are familiar with it. We spoke of it here a few minutes ago, No. 1620, and I ask you whether or not—that was introduced in the Senate February 28, 1939—and I ask you whether or not that bill, known as the National Health Act of 1939—in the first place, was that the one you were talking about in San Francisco when you spoke?

Dr. **Parran.** That is my recollection.

Senator **Donnell.** In the second place, is that not a bill which merely relates to grants to States, as illustrated on page 2, title 5, "Grants to States on Maternal and Child Welfare"; page 5, "Payment to States"; page 10, "Approval of State Plans"; page 13, "Payments to States"; page 15, "Operation of Plans"; page 16, "Public Health Work and Investigations"; page 18, "Approval of State Plans"; page 20, "Payment to States"; and on page 25, title 12, "Being an amendment to the Social Security Act, title 12, 'Grants to States for Hospitals and Health Centers' "—with various other references to approval by States and payment to the States; and then title 13, on page 34, "Grants to States for Medical Care"; and again on page 41, title 14, "Grants to States for Temporary Disability Compensation."

Is it not true that that bill from cover to cover is a bill providing for grants to States in aid?

Dr. **Parran.** That is correct.

Senator **Donnell.** And it is based on the same identical theory of the grants-in-aid in S. 545, is it not?

Dr. **Parran.** The approach in each of the two bills is somewhat similar; and you will recall, Senator Donnell, in my formal testimony I said if the Congress decides to adopt a limited approach to this problem, that the basis, the concept of grants to the States, aid to the States in developing better medical care, is all to the good with the amendment I have suggested.

Senator **Donnell.** I recall that.

Senator **Murray.** May I ask a question there?

Senator **Donnell.** Yes.

Senator **Murray.** Did the medical profession accept this bill and support it?

Dr. **Parran.** Quite the contrary.

Senator **Murray.** They didn't support this?

Dr. **Parran.** Quite the contrary.

Senator **Murray.** How did that happen? I assumed they are entirely in accord with the examination that is going on here. Is not that a fact? Is it not a fact that they support that kind of program now?

Dr. **Parran.** They seem to, Senator Murray, and I think one must recall that in this connection, just as medical science changes and grows, so do our social concepts change and grow, and that is true of the medical profession as well as of other groups of the population.

years that
ary health

insurance
go.
ssociation
be misin-
d in their

during all
in regard

medicine
nowledge,
nodify our

rd to the
nerally.
with ref-
ould make

nit me to
the Sena-

Senator Donnell. In other words, the title II to which you refer in the sentence which I quoted—

> Most of the concepts of title II of S. 545 seem to me to be sound, with some modifications which I shall specify—

that title II which begins on page 12 of S. 545 and includes within it various amendments to the Public Health Service Act, including the amendment which would be known as title VII, appearing on pages 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and part of 27 of S. 545; is that correct?

Dr. Parran. It is correct, if I may make a minor and technical correction.

Senator Donnell. Yes.

Dr. Parran. In the part of my testimony to which you refer I was making reference to the language of S. 545, beginning at the top of page 14.

Senator Donnell. And continuing for how many pages? That continues down through what page?

Dr. Parran. The whole $200,000,000 proposal.

Senator Donnell. That would run on through as to the general medical service to line 7 on page 27?

Dr. Parran. Correct.

Senator Donnell. And then does your comment to which I have referred, namely, that most of the concepts of title II seem to you to be sound, with some modifications which you shall specify, apply also to title VIII, beginning on page 27 of S. 545 at line 8 and running through page 40 at line 8?

Dr. Parran. Yes; substituting the term "dental" for the general principles; yes. I tried to be brief in my statement.

Senator Donnell. And also does your commendation of the concepts, with the modifications to which you referred, apply also to the remainder of the act from page 40 on down through page 47?

Dr. Parran. From page 40 through 44, title IX—proposed title IX—Public Health Act, further research and training in regard to dentistry. The Public Health Service is on record as favoring dental research, and I believe almost the same provisions are contained in a separate bill, which I think I was told the committee reported favorably a few days ago.

Senator Smith. It is on the calendar now. I reported it yesterday.

Senator Donnell. So your comment applies on page 40 through page 44, proposed title IX?

Dr. Parran. Yes, sir; with emphasis on the need for dental research.

Senator Donnell. And does your commendation, with modifications referred to in your statement, apply likewise to the portion of the bill beginning at line 19 on page 44 and running down through line 6 on page 46?

Dr. Parran. That is a complicated question, Senator. I must reiterate my objection to the administrative provisions of S. 545, and the miscellaneous provisions which you have just stated relate, among other things, to such administrative provisions.

Senator Donnell. Yes, sir. Very well, Dr. Parran. Now, Doctor, I shall not trespass but just a short while further on your time.

has been
nt, does it
this time?

through a
That is

s; yes.
hey act as
ical Asso-

I assume,
pressed on
tion-wide

n of that

ny before

much.

ith refer-

Assuming the Congress would enact S. 1320 in its present form or in some similar form, how would it be implemented?

Dr. PARRAN. I would suggest a staggered time table, Senator. The first beginning date, in my view, should be for a program to upbuild our preventive health services, upbuild the local health units, without which neither S. 545 nor 1320 could operate most effectively.

We need preventive health services to blanket the Nation, and we need to intensify the services in areas which have only a partial or even a skeleton force.

At the same time, I would hope that the act would authorize substantial aid to medical education concurrently with the intensified preventive services, because on that score, as well as on the treatment side of the problem, additional personnel are needed.

Perhaps the provisions of the Hospital Survey and Construction Act should be liberalized, as I have indicated—its time to be extended, the amounts authorized thereunder to be increased—if the Congress has in mind the broad comprehensive program as contemplated under S. 1320.

Senator SMITH. May I interrupt? Up to that point, would you put the pay-roll tax on or are you holding off?

Dr. PARRAN. I think the pay-roll tax should follow after some period of time, which the Congress could determine more wisely than I.

Senator SMITH. You would finance those beginning steps much as S. 545 calls for?

Dr. PARRAN. Except that S. 545 doesn't contain either one of the substantial initial steps that should be taken; namely, much broader support to current local health services, except for dental care.

Senator SMITH. It would, in cooperation with the State health organizations, if they see fit to put their money in that field.

Dr. PARRAN. Perhaps, Mr. Chairman, we do not have a meeting of minds as to terms, but the primary purpose of S. 545 is to give $200,000,000 for the medical care of the medically needy. I would put the first emphasis—I would make the initial step a further intensification of efforts to prevent disease, minimize the risk of illness rather than to assume the current volume of illness and seek to spread the cost through taxation or insurance.

The next step, Senator Pepper, in further response to your question, should be the imposition of the pay-roll tax, and that date should be several months or even a year or two or more, in advance of the passage of such a comprehensive provision.

In making this statement, I am expressing my professional point of view and not attempting to express the views of anyone else.

Senator PEPPER. That is what I want because that question is often asked.

Dr. PARRAN. If I may just conclude that line of thinking—unless an act is passed which does set a national policy, we shall never bestir ourselves to get geared up to do this total job.

Senator PEPPER. In other words, the act is somewhat like the planning of the war in the highest level. The Joint Chiefs of Staff, for example, lay down the strategy and lay down the objectives, and then you set in motion the various programs and plans that are designed to implement these objectives that have been declared.

early what
n and then
s. But it
plementa-
ives; isn't

a medical

sional life,

here come
ic unfilled
r country?
e years.
ut of your
care being
compared

t medicine
The torch
this field

Now, you have expressed an opinion, Doctor, in your statement on page 2 at the bottom of the page, and I thought you put it very well, where you summed up in a cautious yet clear way your conviction about this matter. You say in the last paragraph of page 2:

> In testimony submitted before the Seventy-ninth Congress the Public Health Service stated the belief that the health needs of the Nation would be met most effectively and in the shortest period of time through a broad program financed in part through health insurance. This position was based not on preference for any particular scheme of social organization or pattern of Government action but rather on the conviction that such an approach would bring us more quickly to our health goals than any plan yet suggested.

That represents your convictions out of a long period of public health service and many years of experience as Surgeon General of the United States?

Dr. Parran. That is my mature professional judgment.

Senator Pepper. Now, Doctor, you haven't heard any of the authors of this bill claim that it pretends to perfection or that it presumes perfection, have you?

Dr. Parran. Quite the contrary.

Senator Pepper. You have heard from both the authors of the bill and those who favor it that it is simply a step in the direction of greater health care for the greatest number of people and that, as Senator Murray says, defects will develop, trial and error will show through experience the necessity of change, but it is in the direction of the best health care for the largest inumber of people.

Doctor, I want to ask you one other question. Reference has been made to the experience of other countries. Would you just summarize briefly what are the medical plans in the other countries of the world?

Dr. Parran. That is a very large order, Senator Pepper.

Senator Pepper. I realize that, and I don't mean for you to go into general details. Is it or is it not a fact that in practically all of the more advanced countries of the world some approach beyond the pay-for-service fee-for-service medicine has been made on the part of the governments?

Dr. Parran. The governments in most of the countries of the world, most of the western democracies, have undertaken some one or another form of health insurance. However, I would have you bear in mind that the experience in Great Britain, for example, which was started in 1912, has proved inadequate, and it is being changed under the stimulus of the conservative government headed by Mr. Churchill and being carried forward by the Labor Party.

That was a limited program. It insured the worker himself, but gave no protection to the dependent members of his family. It did provide, and most health insurance schemes do provide for cash payments in lieu of wages when one is sick. Up to now this important point has been overlooked in testimony. I think Mr. Mitchell may later develop it. However, it doesn't make sense to me for a person when he is unemployed because a factory is closed to get a cash payment and yet if he has tuberculosis or pneumonia, not to get payment in lieu of wages, except as has been brought out, in the case of Rhode Island.

Senator Pepper. Congress has already laid down that principle in the amendment to the Railway Labor Act, which went into effect in July of this year.

s?
elieve we
t science.
operation.
ent basis
example,
eally can
gs before
of other
ystem. I
the Con-
ple as to
d out of
the em-
eyond my

any plan
e in char-

le. Ade-
ealth for
of health
to attain

(The two documents referred to above are as follows:)

[Fact sheet I]

Health Insurance

I. How many people in the United States need help to meet the cost of serious illness?

1. Two people out of every three, approximately 97,000,000 Americans, need help to meet the cost of serious illness.[1]

II. How often are people ill?

1. Among each 1,000 persons, during a normal year: 1 out of 3 will be sick once, 1 out of 7 will be sick twice, 1 out of 20 will be sick three times. In addition, many more will suffer unrecognized illnesses, such as heart diseases or cancer in the early stages, so that over half the people in the country are sick at least once during the year.[2]

2. At least 7,000,000 people in the United States are disabled by sickness or other disability in any 24-hour period, half of them for 6 months or more.[3]

(*a*) One person out of every 20 is afflicted by sickness or disability in any 24-hour period.

III. How many doctors are there in the United States?

1. There were 180,496 registered physicians, including all types of specialists, in 1942.[4]

(*a*) We had about 135, 932 "effective physicians" in 1943.[5]

IV. Is there a shortage of doctors in the United States?

1. Yes. There is a 40- to 50-percent shortage, taking a standard of 1 physician for every 1,000 potentional patients.[6]

(*a*) There would be only 1 active physician for every 1,000 to 1,500 potential patients, as against a recognized standard of 1 for every 1,000, if doctors were distributed evenly across the country.[6]

(*b*) However, there is less than 1 active physician for every 3,000 people in 18 percent of the Nation's 3,070 counties; and 81 counties have no active doctor at all.[7]

V. How many hospitals and hospital beds are there in the United States?

1. There were 1,738,944 hospital beds in 6,511 hospitals in 1945.[8]

(*a*) However, there is no approved general hospital in 41 percent of the Nation's counties, with a total population of 15,000,000 people;[3] and 48 percent of our counties have less than the recognized standard of 4.5 beds for every 1,000 people.[9]

VI. How much do illness and death cost the people of the United States?

1. About $15,000,000,000 a year. This is the estimated total hidden cost of sickness and disability, wage loss to workers, and cost to business.[10]

(*a*) The estimated annual cost of sickness and accidents, in medical costs and loss of earnings alone, due to sickness and premature death, is $8,000,000,000.[3]

2. It has been estimated that the people of the United States will spend $5,499,963,211 in 1947 for medical care, including supplies and insurance.[11]

(*a*) In contrast with this, we spent $8,700,000,000 in 1946 for alcoholic beverages—50 percent more for alcoholic beverages than for every form of medical care, including supplies and insurance.[12]

---

[1] Families with incomes under $3,000 need help to meet the cost of serious illness (Factual Data on Medical Economics," pamphlet issued in 1939 by the Bureau of Medical Economics of the American Medical Association). 69 percent of the United States population live in such families (National Survey of Liquid Asset Holdings, Spending and Saving: Bureau of Agricultural Economics, U. S. Department of Agriculture, July 1946).

[2] I. S. Falk, C. Rufus Rorem, and Martha D. Ring, The Cost of Medical Care, Publication No. 27, Committee on the Costs of Medical Care, University of Chicago Press. (Figures are minimum, for recognized illnesses only.)

[3] Senate Subcommittee Report No. 5 (Health Insurance), July 1946, p. 1.

[4] A. M. A. Directory, 1942, 8 (latest issue).

[5] A. M. A. Journal, vol. 121, p. 1163 (1943) : Total registered physicians, 1943 : 179,039 ; difference represents those not practicing because of advanced age, physical disabilities, and other reasons.

[6] Senate Committee Print No. 5, 79th Cong., July 8, 1946, p. 35.

[7] Senate Subcommittee Report No. 5, 79th Cong., July 1946, p. 1.

[8] World Almanac, 1947, p. 773.

[9] Senate Committee Print No. 3 (National Health Act of 1945), March 1946, p. 52.

[10] Federal Security Agency fact sheet, The Health of the Nation, June 1, 1946, p. 2.

[11] The Medical Market—Forecasts for 1947 (Modern Medicine).

[12] Department of Commerce, April 30, 1947 (AP dispatch, Washington, New York Times).

l cures to

ntary and
new treat-

ed in 1943
industrial

griculture
nd animal

the United

le less, on
g table:[16]

---

roposed bill [2]

$15-$30
30- 45
75- 90
90-150

August 1942,

y form of

XI. What do public opinion polls show about popular demand for health insurance?

1. In a national poll in 1944:[22] 82 percent thought something should be done to make it easier for people to get medical care; 85 percent thought social security should include doctor and hospital care; 58 percent were willing to pay 2½ percent pay-roll deduction to provide the money (the proponents of the present bill suggest only 1½ percent deductions).

[Health insurance fact sheet II]

I. How many people in the United States need help to meet the cost of serious illness?

1. Two people out of every three who live in the United States—about 97,000,000 Americans—need help to meet the cost of serious illness.[1]

(*a*) This statement is based on an estimate made in 1939 in a publication of the American Medical Association, that families with incomes under $3,000 need help to meet the cost of serious illness.[1]

(*b*) However, by 1945 the cost of living index had increased by 29 percent over 1939; and in April 1947, the index was 50 percent higher than in 1939.[2]

(*c*) Therefore, it is reasonable to assume that many people with incomes over $3,000 now need help to meet the cost of serious illness.

II. What is the annual loss to the United States because of sickness, disability, and premature death?

(A) In terms of people, the United States lost:

1. In 1945, excluding those who died in the armed forces overseas, 1,401,719 Americans, through death. Of these:[3] (*a*) 11 percent or 162,006 were under 20 years of age; (*b*) 8 percent or 112,442 were aged from 20 to 39; (*c*) 19 percent or 274,448 were under 40 years of age; (*d*) 23 percent or 321,921 were aged from 40 to 59.

This means that (*e*) 42 percent or 596,369 of the Americans who died in this country in 1945 were under 60 years old.

2. About 1,000,000,000 days of disability each year from chronic illnesses.[4]

(*a*) There are approximately 22,000,000 disabling illnesses every year in the country as a whole.[5]

(1) Each of these illnesses lasts, on the average, about 57 days.[5]

(*b*) Over 40 percent of the Nation's selectees were found unfit for military duty.[6]

(1) At least 17 percent of those found unfit had defects which were remediable; many more had preventable defects.[6]

(B) In terms of production, the United States lost:

1. About 600,000,000 man-days annually.[7]

(*a*) Illness and accidents cause the average industrial worker to lose about 12 days from production each year.[7]

(*b*) More than 75 percent of the 25,000,000 chronic disease cases in the United States are among people in the productive years from 15 to 64; half of these people are less than 45 years old; 16 percent of them are under 25.[8]

(C) In terms of money, the United States lost:

1. An estimated $8,000,000,000 annually, half in medical costs and half in loss of earnings due to sickness and premature death.[7]

(*a*) It is estimated that American workers lost $560,000,000 in wages in strikes during the first 6 months of peace; at this rate, the annual wage loss t through

---

[22] National Opinion Research Center, University of Denver. (Quoted in Federal Security Agency fact sheet, The Health of the Nation, June 1, 1946.)

[1] Families with incomes under $3,000 need help to meet the cost of serious illness (Factual Data on Medical Economics, pamphlet issued in 1939 by the Bureau of Medical Economics of the American Medical Association). 69 percent of the United States population live in such families (National Survey of Liquid Asset Holdings, Spending and Saving: Bureau of Agricultural Economics, U. S. Department of Agriculture, July 1946).

[2] Bureau of Labor Statistics: 1939 yearly average, 99.4; 1945 yearly average, 128.4; April 1947 (monthly average), 156.1 (1935–39=100).

[3] U. S. Bureau of Vital Statistics.

[4] George St. J. Perrott, U. S. Public Health Service: The Problem of Psychosomatic Disease, article in Psychosomatic Medicine, January 1945.

[5] Public Affairs pamphlet, Who Can Afford Health? by Beulah Amidon, 1944, p. 9.

[6] Senate subcommittee Rept. No. 5, 79th Cong. (Health Insurance), July 1946, p. 1.

[7] Senate subcommittee Rept. No. 5, 79th Cong. (Health Insurance), July 1946, p. 1.

[8] George St. J. Perrott, U. S. Public Health Service: The Problem of Chronic Disease; article in Psychosomatic Medicine, January 1945.

disability
less than

on other

f the total

will spend
nsurance.[12]
45 (latest

rotect our
ed defense
es against

ny and Air
61,000 for
plies, and

the people
plies, and
olic bever-
on over 18

in a year.
h do they

ed States.

(*b*) Taking 4.5 beds per 1,000 population as the standard for hospitals:[24] (1) Only 11 percent of the counties of the United States meet this standard;[25] (2) 48 percent of the counties in the United States have under this standard;[25] (3) 41 percent of the counties in the United States have no approved general hospital.[25]

(*c*) 16,257,402 patients were admitted to hospitals in 1945, or an average of about one out of every eight people in the United States.[22]

2. Of 15,800,000 patients admitted to registered hospitals in 1944:[26] 95.1 percent or 15,000,000 were admitted to general hospitals having 54 percent of total beds; 2.9 percent or 500,000 were admitted to special hospitals having 3 percent of total beds;[27] 1.4 percent or 200,000 were admitted to nervous and mental hospitals having 38 percent of total beds; 0.6 percent or 100,000 were admitted to tuberculosis hospitals having 5 percent of total beds.

VI. How much do we spend for research for new treatments and cures to save our people from death or disability?

1. It is estimated that only about $20,000,000 a year is being spent for research to find cures and new treatments of diseases.[28]

(*a*) In contrast with this, the Department of Commerce reported in 1943 that approximately $275,000,000 is being spent each year for industrial research.[29]

(*b*) In 1947, Congress appropriated $29,866,200 for the Department of Agriculture alone, for research in the control and cure of plant and animal diseases.[30]

(*c*) In contrast with the 1947 total appropriation of $104,088,516 for the United States Public Health Service, Congress made a total appropriation of $744,489,692 in 1947 for the Department of Agriculture.[30]

VII. How much more would a national health insurance program cost the people of the United States than they spend under the present system?

1. It is estimated that about $5,499,963,211 will be spent by the people of the United States for medical care in 1947, including medical services, medicines and supplies, and health and accident insurance.[31]

2. In a study made in 1941, it was found that money spent by sample family groups for medical care was distributed as follows:[32]

	Health and accident insurance	Medicines and supplies	Medical services	Total
Groups with incomes between $500 and $1,000	$2.13	$9.16	$15.14	$25.12
Groups with incomes between $1,000 and $1,500	4.48	16.28	37.15	57.91
Groups with incomes between $2,500 and $3,000	7.83	18.06	63.99	89.88
Groups with incomes between $3,000 and $5,000	11.39	33.99	107.69	153.07

---

[24] Public Health Bulletin, No. 292, Health Service Areas. Issued by U. S. Public Health Service, 1945, p. 5. (Estimate does not include beds for patients suffering from utberculosis or mental disorders.)

[25] Senate Committee Print No. 3, 79th Cong. (National Health Act of 1945, and Hospital Survey and Construction bill.) March 1946, p. 52.

[26] Senate Committee Print No. 4, 79th Cong. (National Health Act of 1945), March 1946, p. 20.

[27] Includes maternity, industrial, eye-ear-nose-and-throat, children's orthopedic, isolation, convalescent and rest, etc.

[28] See the following table:

American private foundations, 1940 (latest estimate)	$4,700,000
National Cancer Institute (U. S. Government), 1946–47	1,772,000
National Institute of Health (U. S. Government), 1946–47	5,966,948
Veterans' Administration—National Research Council (approximate)	1,000,000
American Cancer Society, 1946	2,500,000
National Foundation for Infantile Paralysis, 1946	1,858,826
Medical schools and teaching hospitals (estimated)	2,500,000
Total	20,297,774

[29] Report of survey released by Department of Commerce in 1943.

[30] Budget of the United States, fiscal year ending June 30, 1948.

[31] The Medical Market—Forecasts for 1937 (Modern Medicine).

[32] Study of Family Spending and Saving in Wartime, 1941 and the first quarter of 1942. August 1942. U. S. Bureau of Labor Statistics and Bureau of Home Economics.

national-
ould be as

___ $22. 50
___ 37. 50
___ 75. 00
___ 108. 00

penditures
d be lower

ou think
e author-
n for the

ifficulties
may well
hospital-
tical part
mstances.
ne doctor.
v he may

le admin-

Dr. PARRAN. I hope I was quoting correctly.

Senator SMITH. Quite correctly.

Senator PEPPER. If the theory of S. 545 is carried out—that is not requiring the individuals to make a public contribution or contribute through a tax or any other kind of compulsory payment, but the money is provided out of the Treasury—does that approach what might be called the socialized system of providing medical services free to the people, free of any direct contribution from them other than through taxes or through the insurance system?

Dr. PARRAN. I think that is a question primarily for the taxation experts because a compulsory contribution is a tax such as income tax is a tax.

Senator PEPPER. I don't know if you happen to know, and I am not sure I am right, but it is my understanding that one difference, for example, between the Soviet system and the British system is that the Soviet system does not require any tax from the citizens. The citizen goes to a hospital and gets medical care, goes to a doctor and gets medical care, just as a man or woman in the Army or Navy goes to the dispensary or to the hospital and get medical care as a service furnished by the Government without paying directly for the service; whereas in Britain they are required to make payments, some kind of pay-roll tax, or some sort of compulsory payment.

Am I correct in that general understanding?

Dr. PARRAN. That is my understanding.

Senator PEPPER. If we furnished through the method of S. 545, the State appropriation, that would be a little nearer to the Soviet system than to the British system, would it not? I am sure the authors would not want to be in that position.

Senator SMITH. I object to the comparison. They both are taxes, either way you put it, pay-roll tax or the others. It is not insurance, it is a tax. Each fellow pays according to his means. The Government undertakes to perform the service.

I would like to ask you this question: Would you think it wise, assuming we adopt a plan like S. 1320, to have the compensation paid in dollars and let the person use the dollars to get the service or should we have an elaborate scheme to determine the set-up of doctors working it out?

Dr. PARRAN. The only way I can see you have any choice of doctors is to be paid money benefits just as we pay unemployment benefits. You would have the patients use that money for contracting for any service needed. That would be in line with our unemployment compensation. That would be the comparison.

If a person has tuberculosis, why not pay for that as well as unemployment?

Senator SMITH. I admit that analogy, but then you get money benefits and then you get into this complicated question of how to deal with the medical profession.

Dr. PARRAN. I would favor money benefits only in partial compensation for wages lost by the breadwinner, by the wage earner, and not for the giving of professional service. I don't believe that a system of cash benefits would be nearly so effective as service benefits.

Senator SMITH. To organize the service and make it practical is the problem.

nd diverse

does differ
our unem-
such con-
pping, and
deliver a
nd that is
re we turn
ifferent as
at tried it
d of that.
t practical
e or call it
ay is a tax.
l, S. 1620,
insurance
large? I
a little of

r the condi-
ls suffering
ncluding all
reatment of
arrying out

by the same methods, and be paid for through the same arrangements as services furnished to individuals eligible for benefits under this title.

I ask you whether or not it is a fact that in order to determine who the needy persons are to whom any or all of these benefits provided under the title in S. 1320 may be furnished—I say in determining who are these needy persons, would not it necessarily involve a test of some kind to determine whether they are financially capable or not?

In other words, is there not a means test provided there to the extent that S. 1320 provides for benefits for persons who are not eligible under the earlier definition of the bill?

Dr. Parran. Senator Donnell, I understand this section to contemplate two groups of individuals, generally speaking. They are those who have already been subjected to a means test and are recipients of relief. This seems to be an invitation to the local public-welfare authorities to pay into the fund equitable reimbursements so that persons on relief or those who have been declared by the public-welfare officers to be medically needy would get care under the one administrative system.

Secondly, I interpret the wage range to be an invitation to the States and their political subdivisions to permit the joining of the system by the public employees.

Senator Donnell. However, Doctor, this section 205 (a) does provide that benefits provided under this title, any or all of the benefits, may be furnished to individuals, including the needy, not otherwise eligible therefor.

Dr. Parran. It provides that. I would again underline the fact that the other provisions of S. 1320 would in times of normal employment perhaps embrace as many as 85 percent of the population, so that the volume of medically needy persons would be much less than contemplated under S. 545, and in respect of most of the "needy persons" referred to in section 205 (a), their needs for all necessities of life probably would have been already determined.

Senator Murray. To be determined by the States.

Dr. Parran. It would have been determined precisely by the local public-welfare agencies.

Senator Murray. They wouldn't be on the pay rolls. Our bill contemplates all those receiving medical care are people having deducted from their pay certain sums each month so that these people who would be needy would be people who are not employed or who are unable to be employed; and, therefore, it would be a very simple matter to determine who they are because the State would be able to furnish the list and there would be no need for a means test under the administration of this act.

Senator Donnell. Doctor, do you know of any means test by which you can find out whether a person is needy without imposing some sort of means test?

Dr. Parran. I don't know of any way.

Senator Murray. The State determines that.

Senator Donnell. The State would determine it in any case.

Senator Murray. The State has already determined it; I assume the people are on relief.

Senator Donnell. The point I am making is that under S. 1320 there is a provision as follows:

> Any or all benefits provided under this title to individuals eligible for such benefits may be furnished to individuals, including the needy.

vhether a

Have you
nto effect

question,
ying for
a precise
ld be re-
prepared

studies of
on that

er for in-
d for and
ne next is
ng this I
greement
tion with
nope that
my testi-

In terms of need, however, as distinguished from effective demand, the deficiencies are serious, and will grow more pronounced in the future. With the development of programs which remove the financial and geographical barriers to medical care, and which create additional facilities for the rendering of health services, the present rate of production of physicians will prove increasingly inadequate. Moreover, there is little disagreement with the facts concerning the serious maldistribution of doctors, leaving many rural and other areas badly underserviced.

Supply of physicians by 1960.—Every calculation indicates the deficiency of physicians to be expected by 1960. It can be estimated that some 111,000 new doctors will be graduated by 1960 at current rates of production. In this time 77,000 will retire or die, leaving a net increase of 34,000.

However, known requirements can be expected greatly to exceed this net increase in number of physicians. An estimated deficit of 30,000 physicians by the year 1960, calculated merely on the basis of current demand, is shown in the following table:

Estimated deficit in supply of physicians, 1940–60

	Number of physicians
Increased needs:	
To take care of increased population at 1940 rates of physicians to population	27, 000
Army, Navy, Veterans' Administration, Public Health Service	16, 000
Health officers and physicians in new hospitals for tuberculosis and mental disease	5, 000
Physicians for new hospitals and health centers under Hospital Construction Act	16, 000
Total	64, 000
Gain by excess of graduates over deaths and retirements	34, 000
Net deficit	30, 000

This 30,000 deficit relates only to the numbers of physicians at current proportions, plus the specific needs of an expanding population and certain public programs. If we are to attempt any estimate of the actual need for more adequate services, such as that for general practitioners in local communities, additional personnel will be necessary. Using the average physician-population ratio in the 12 best-supplied States to represent an attainable standard of "adequate care," then still another 30,000 practitioners would be needed to raise all States to this level by 1960.

The estimated total number of physicians, including specialists and public-health administrators, which would be required for "adequate care" in 1960 reaches a minimum of 270,000 when based on the standards of the 12 currently best-supplied States. Since only about 175,000 doctors were reported in 1940, and only about 209,000 can be anticipated at current rates of production by 1960, the achievement of the desired goals will require a substantial increase in the current output of our medical schools extending over a long period of years.

Obviously, any feasible increase in the training program now would be well justified by the need. The production of the 30,000 additional doctors needed as a minimum by 1960 would hardly be achieved before that date even with a 50 percent increase in annual output by existing schools. Actually, a training program starting in 1948 would produce no finished doctors until 1953. Thus, nearer a 75 percent increase in the number of graduates during the years before 1960 would be necessary to produce the doctors needed to meet existing commitments by that date.

2. *Dentists.*—There is no question about the absolute and relative shortage of dentists, now and in the future. The present total number of dentists, some 75,000, cannot begin to meet the need for dental care. The accumulated dental neglect in the population is so great that it has been estimated that 800,000,000 hours of work would be required to do the job. This would take 400,000 dentists working full time for 1 year on just existing defects. The most conservative estimates indicate an immediate requirement of about 100,000 active dentists, if dental hygienists are trained and used to a larger extent than they are now. One hundred and sixty-five thousand dentists are needed if present conditions of practice remain unchanged.

, with many
Agriculture
rural areas
1,400. The
be reached
ntal schools.
urses exist,
s are needed
tremendous
of 62 nurses
00,000.

1947, even
rrent deficit
e additional
under way.

ded medical
nown today.
yarn us that
skotten has
ts; Johnson
d Allen has
).

nel must be
rable funds
ools without
est third of
tten[1] would

This is about $10,000,000 per year over the period of the next 12 years. It should be repeated at this point that this amount of money would not begin to finance the needed improvements in existing schools, nor would it cover the costs of the new plants that would be necessary if the full personnel deficit is to be eliminated.

2. *Dentists.*—Similarly, the most modest estimate of an immediate need for at least 25,000 more dentists implies a training cost of a minimum of $100,000,000, figuring a 4-year dental school course and $1,000 per student per year unit cost after subtraction of tuition fees paid by students.

This is an immediate need, but even if projected ahead until 1960 (at which time many more dentists will actually be needed), a minimum annual expenditure of some $8,000,000 will be necessary. The inadequacy of the present dental schools to overcome the shortage is, perhaps, even more pronounced than that of the medical institutions.

3. *Nurses.*—It is almost impossible to give any reliable figures for the unit costs of nurses' training, due to the extremely wide variations in costs at the various nurses' schools. A very rough gage can be obtained from the Federal cadet nurses' training program during the war, when the average cost of training a nurse (including small stipends to the students) totaled about $1,200. Using the 1946 deficit figure of 42,000 nurses it may be estimated that the total cost of financing the training of the needed numbers of nurses would be about $50,000,000.

If these costs are also to be spread over the years until 1960, the annual outlay would have to be in the neighborhood of $4,200,000. It must be repeated that these figures are exceedingly rough, and that the items here included for tuition, uniforms, etc., might be paid for in part by the students themselves during a peacetime program.

STATUS OF STATE HOSPITAL SURVEY AND CONSTRUCTION PROGRAM

State plans

Three State plans, those from Mississippi, Indiana, and North Carolina, have been received in the central office, and those from Mississippi and Indiana already have been recommended for approval. Others, including Oklahoma, have been completed and are in transit from the district office. Our district staffs estimate that approximately 40 States will have plans completed before the end of this calendar year.

The plans which we have had an opportunity to study here are the result of a remarkable amount of careful planning. These plans have been submitted by Indiana, North Carolina, and Mississippi.

	Number of beds		
	Existing acceptable	Additional	Total
Indiana:			
General	7, 203	8, 123	15, 326
Chronic	79	6, 696	6, 775
Tuberculosis	1, 136	1, 917	3, 053
Mental	8, 264	8, 673	16, 937
North Carolina:			
General	8, 510	7, 916	16, 426
Chronic	0	6, 668	6, 668
Tuberculosis	1, 830	1, 660	3, 490
Mental	6, 072	10, 598	16, 670
Mississippi:			
General	2, 988	5, 989	8, 977
Chronic	125	3, 855	3, 980
Tuberculosis	458	1, 975	2, 433
Mental	4, 408	5, 542	9, 950

New health centers and auxiliary facilities have been planned, as follows:

	Health centers	Auxiliary facilities
Indiana	36	
North Carolina	89	14
Mississippi	53	159

ncide quite
f the other
timates will

al facilities
lth centers,
n as related
the follow-
population ;
nental hos-
r thousand

ch category

mated cost
Replacement
$503, 334, 000
86, 565, 000
298, 749, 000

will have to be done before we can really feel complacent about our health progress.

There are 24 States which exceed the infant-mortality rate for the country. If we could bring these States to the national average, it would mean a saving of 8,500 lives per year. The saving would be double this figure if the national rate were the same as that now prevailing in our best 5 States.

A great saving of lives would be effected if we could bring to all sections of the country the progress that has been made in our best States. When we observe that the range among the States is such that maternal mortality is relatively 4 times as great in one as in another, cancer and disease of the heart three times as great, and pneumonia two times as great, we begin to realize the magnitude of the task before us.

Many of the causes of death, such as pneumonia and diseases associated with childbirth, are preventable, and therefore good prevention programs are needed. For others, we need more intensive research to discover etiology and cure, and increased facilities and personnel to lessen the suffering of the sick.

TABLE A.—*Mortality in 1944, by place of residence*

[Data not adjusted for age]

	Per 1,000 live births		Per 100,000 population, 1944					
	Infant mortality	Maternal mortality	Total mortality	Tuberculosis	Cancer	Diabetes	Diseases of heart	Pneumonia
United States	39.8	2.3	1,064.7	41.3	129.1	26.4	315.4	61.7
Alabama	45.5	3.7	928.6	45.0	73.9	11.7	181.2	73.7
Arizona	68.8	3.0	972.7	[1] 122.9	80.9	[2] 8.3	170.7	68.8
Arkansas	34.7	2.8	817.3	46.5	74.4	11.0	169.4	68.1
California	34.5	1.7	1,037.0	43.7	131.8	21.6	327.1	53.2
Colorado	49.4	2.5	1,068.7	36.5	126.2	19.2	277.9	82.9
Connecticut	30.7	1.5	1,065.5	37.2	165.6	35.4	357.6	44.0
Delaware	48.7	1.5	1,177.7	43.3	126.8	29.9	359.8	65.1
District of Columbia	44.8	2.1	880.7	58.6	115.1	22.3	247.1	[3] 41.6
Florida	45.5	3.3	992.0	34.7	92.4	17.4	222.2	62.8
Georgia	44.5	3.6	912.4	35.4	71.1	11.9	177.9	71.6
Idaho	34.0	2.5	[4] 876.2	20.4	100.3	17.8	229.1	54.2
Illinois	32.4	1.8	1,140.6	41.6	160.6	34.0	399.6	43.5
Indiana	34.5	2.0	1,151.8	35.7	135.0	27.7	334.4	65.1
Iowa	33.1	1.8	1,149.8	15.0	157.9	28.3	354.7	66.1
Kansas	33.3	1.8	1,044.8	20.1	130.0	27.0	297.9	53.3
Kentucky	46.7	2.5	1,079.7	65.7	102.9	18.6	264.2	[5] 89.3
Louisiana	46.3	3.4	929.9	45.7	92.6	16.1	245.0	68.8
Maine	46.7	2.3	1,295.1	35.2	170.0	25.6	381.6	73.3
Maryland	41.5	1.9	1,064.5	62.3	122.0	28.6	324.2	58.8
Massachusetts	33.1	1.8	1,241.5	40.8	182.7	37.5	448.2	66.8
Michigan	37.9	1.7	1,001.9	33.4	128.0	26.8	313.2	52.6
Minnesota	31.3	1.4	1,053.8	27.6	149.6	29.0	321.5	67.5
Mississippi	44.1	3.8	949.6	38.2	74.2	13.6	164.2	65.0
Missouri	37.6	2.2	1,177.1	41.4	146.6	25.2	350.3	84.9
Montana	36.1	1.5	1,218.0	37.6	146.5	27.1	357.1	64.5
Nebraska	33.0	1.7	1,037.5	17.4	137.1	27.4	297.1	59.7
Nevada	50.2	2.3	1,053.2	48.6	101.0	12.8	229.6	68.4
New Hampshire	37.7	2.8	1,353.7	23.0	[6] 187.4	38.9	446.4	80.7
New Jersey	34.0	1.6	1,147.4	44.5	165.2	35.6	392.3	49.1
New Mexico	[7] 89.1	[8] 4.0	1,034.1	64.9	[9] 63.6	10.2	[10] 144.6	82.9
New York	32.8	1.9	1,205.9	47.9	178.7	[11] 42.6	[12] 453.7	52.0
North Carolina	45.4	2.9	832.2	35.1	65.9	14.4	180.9	56.4
North Dakota	35.4	1.8	968.6	16.3	123.2	28.0	263.2	52.4
Ohio	38.5	1.9	1,173.6	40.8	146.8	32.4	356.5	66.1
Oklahoma	41.2	2.4	917.0	42.6	99.8	16.3	205.8	61.7
Oregon	[13] 30.5	1.8	1,083.6	25.3	137.3	21.8	306.9	58.9
Pennsylvania	40.0	2.5	1,194.5	43.5	151.1	36.6	385.2	71.2
Rhode Island	35.3	1.8	1,075.6	38.4	137.4	37.2	385.0	57.0
South Carolina	54.9	3.7	945.0	34.4	66.1	16.3	188.1	75.4
South Dakota	34.9	1.8	1,011.7	31.9	129.6	23.5	267.3	56.8
Tennessee	45.5	2.8	971.2	65.6	89.0	13.1	209.4	78.9
Texas	50.4	2.5	894.9	45.4	82.2	14.6	196.0	62.0
Utah	33.9	1.4	817.5	[14] 12.0	90.0	18.3	243.4	42.2

Footnotes at end of table.

ed

4

seases heart	Pneu- monia
441.3	69.4
224.5	61.6
327.1	59.2
224.5	69.3
333.6	55.4
232.2	53.8

ital Statistics—
tal Statistics of
iable I. Death

one para-

ituations in
epartments

who have sent stamps will be adjusted as soon as I am able to attend to the matter.

I am going ahead with the third printing of the Blueprint, and shall continue to fill orders. The pamphlet becomes of especial importance in view of the introduction of the new WMD bill.

I should like to take this occasion to thank you for many kind expressions of interest in what I have endeavored to do in the public interest. Pressure groups have been trying for months to have me silenced. It is important to them that I should not present the facts about political developments affecting medicine, especially at this time. At this moment my only comment is that during the 35 years of my professional life, I have never made any decision as to my own next step on the basis either of expediency or of financial rewards. In the few remaining years of my professional career I shall not change a lifetime pattern regarding my own conduct. I think the issues at stake are of very great importance, I do not intend to play a passive or negative role.

MARJORIE SHEARON, Ph. D.,
Chevy Chase 15, Md.

Dr. PARRAN. Thank you very much. I hope in my comments as a result of an effort to save your time and be brief I have not appeared to be dogmatic.

Senator SMITH. I appreciate very much the substance and spirit of your testimony.

I have on the list of remaining witnesses Katharine Lenroot of the Children's Bureau and William L. Mitchell, Acting Commissioner for Social Security. I don't know who wants to come first. We have a requirement of the committee that prepared statements be presented, so I would prefer to have the prepared statements and then comments on them.

Miss LENROOT. Mr. Chairman, I am here to amplify and answer any questions that I can in regard to Mr. Mitchell's statement.

Senator SMITH. Very well.

STATEMENT OF WILLIAM L. MITCHELL, ACTING COMMISSIONER FOR SOCIAL SECURITY

Senator SMITH. Mr. Mitchell, I take it you are here as Deputy Commissioner of the Social Security Administration. I take it you are appearing for the Social Security Administration.

Mr. MITCHELL. That is right. If the committee would like, I have prepared a summary of that more lengthy statement which is just about half its length.

Senator SMITH. Yes; I would like to have you present that. However, we will include your longer statement in the record at this point.

(Mr. Mitchell submitted the following brief:)

STATEMENT OF WILLIAM L. MITCHELL, ACTING COMMISSIONER FOR SOCIAL SECURITY, ON S. 545 AND S. 1320

Mr. Chairman, I wish to express our regrets that Mr. Altmeyer, the Commissioner for Social Security, is not able to be here to testify at these hearings on behalf of the Social Security Administration. He is abroad, serving temporarily as Executive Secretary of the International Refugee Organization. I am sure that he would have been glad to have had this opportunity to come before your committee. He has a very deep interest in the subject under consideration, to which he has given much attention over a period of more than 25 years, and he regards it as one of the most important aspects of our whole American program for social security.

The Social Security Administration has administrative responsibilities for several programs which are directly in the fields with which S. 545 and S. 1320

ion, admin-
others and
e, also part
c assistance
States and
edy persons
e is Federal
there is no

sponsibility
ost effective
and as to
e pensions,
l subjects"

ial Security
dertaken to
of law. It
am bureaus
of economic
ovisions are
l to develop

ies working
ne opinions,
viduals and
ld be made

endorsement of the goals and principles proposed in that report on a national-health program" (p. 15).

Similar recommendations continued to be made annually. The last report submitted by the Board (1946) said:

"To attain the objectives of a social-security program, the Board believes social insurance and public assistance, separately or in combination, must provide against all common hazards to livelihood among all groups of the population. Our present provision for social security in the United States is seriously deficient in both these respects" (p. 427).

And the Board's recommendations for particular programs included, among others, the following:

"Insurance against costs of medical care, including payments to physicians, dentists, nurses, hospitals, and laboratories, with provision for decentralization of administration and utilization of State administration * * *" (p. 430).[1]

I cite these excerpts to emphasize again that the opinions expressed by Mr. Altmeyer last year, and which I reiterate, were the product of many years of deliberation, and they were the unanimous recommendations of the Social Security Board. The Board's consistent urging of more adequate provisions for health services and for protection against sickness costs was primarily the result of observations from all areas in which our personnel had dealings with persons in need of aid and for whom our present programs give only partial aid or none at all. It is still our conviction that the inadequacy of health provisions and the inadequacy of social security against sickness remain among the serious threats to economic security in this country.

In this connection, I want to express our opinion that a program for security against the costs and losses caused by sickness is inherently both a social-security program and a health program. Both aspects must be taken carefully and fully into account. A sound program will be one that is effectively coordinated with other measures for social security and with other measures for health. Moreover, a health-security program will fail to meet existing needs if it provides only for needy persons; an adequate program must also deal with the problems of self-supporting people.

GENERAL RECOMMENDATIONS OF THE SOCIAL SECURITY ADMINISTRATION

Since Commissioner Altmeyer testified comprehensively at the Senate hearings last year, and his testimony is available in the published record,[2] I have not undertaken to reassemble and repeat the grounds for our recommendations. The picture has not changed materially since then; there is no reason to believe that needs have changed in any basic way. Resources for constructive measures have increased through the return to civilian life of many medical and related practitioners who had been in the armed forces, and through the enactment of Federal legislation to provide aid for State surveys of hospital resources and for the construction of some of the needed facilities.

I would like to identify four broad problem areas in which constructive programs are needed. My remarks about them should be considered in conjunction with those contained in Mr. Miller's and Dr. Parran's testimony.

1. *Prevention of disease, disability, and premature death.*—While the Social Security Administration does not have primary administrative responsibility in this field, it is responsible for the health programs administered by the Children's Bureau, and it deals all the time—through the social insurance and the public assistance programs—with insecurity and dependency resulting from disease, disability, and premature death. Consequently, the Administration has a responsible interest in the adequacy of the public health programs. It believes that strong preventive programs are essential elements in any broad undertaking for the social security of the American people.

We appreciate that the Congress has already gone a long way, over the past 12 years, in developing and financing public health programs. But we are also aware that much still remains to be done. From our point of view in administering social-security programs, there is not much sense or economy in spending large sums of money merely to repair social and human damage that can be prevented from occurring. We are confident that the social insurance programs will be strengthened and the public assistance programs will be substantially ature death

---

[1] A more extensive excerpt from the Annual Report for 1946, giving the basis for the Board's recommendation, is attached.

[2] Hearing before the Senate Committee on Education and Labor on S. 1606 (79th Cong.), pt. 1, pp. 169–208.

h needs of
hetic atten-
s for these
shed under
the present
l children's
fare. Much
ted in these

tee on Edu-
nsive state-
children in
health and
ecurity Act,
nd children
in part be-
ot on State-
en sufficient

re very im-
e kind that
nothers and

n give added
designed to
are needed.
nedical care,
n. In times

In this connection I would emphasize that any action which you may contemplate in this area should, I believe, take full and careful account of the inherent and inevitable interrelations between health provisions for the needy and other general provisions for them, especially if the health services were to be administered separately. When assistance authorities look at the budget needs and the budget deficiencies of people who apply for aid they have to take health needs into account. What decisions they make in each individual case, therefore, have to take account of medical-care provisions under health programs if medical services for the needy are separately provided. Coordination is, therefore, important lest there be gaps or overlaps, and both the welfare and health programs suffer as a result.

4. *Prepayment of medical costs for self-supporting families.*—The largest problem area to which I direct attention concerns the general field of prepayment for medical care. The nature and the dimensions of this area suggest that the Congress should not confine its attention to the medical needs of those who are forced to seek public aid for essentials of living or for those who are under some very low income amount, but should also consider provisions for that large proportion of the population—ordinarily self-supporting—who cannot manage the costs of medical care on an individual or family basis or who can do so only with great difficulty or sacrifice. The need for such provision is now widely accepted, as is the use of the prepayment method as the means. As Mr. Miller pointed out, major differences of opinion have, for the most part, narrowed down to a choice between the alternatives of voluntary and compulsory insurance. We believe "that the simplest, most economical, and most effective basis for medical care insurance would be through Federal legislation to establish comprehensive protection" (Annual Report, 1946, p. 442).

These four problem areas are not altogether separate or additive; the content of each one has to be considered in light of the others. The scope of public-health developments through community provisions and the scope of special provisions for mothers and children are interrelated. Also, both of these programs deal with sectors that are important for the third, medical care of the needy. And all three of these programs have important interrelations with the characteristics of a prepayment program for selfsupporting persons.

In making any decisions as to legislation with respect to any of these four areas, we recommend—

(*a*) A public-health program that will, as soon as practical, and along lines suggested by the Administrator and the Surgeon General of the Public Health Service, assure all needed community-health services throughout the country;

(*b*) A comprehensive national system of social insurance against medical costs (and also against earnings lost on account of disability);

(*c*) A program of maternal and child-health and crippled-children's services sufficient to assure, as soon as practical, all needed services not otherwise available; and

(*d*) A more adequate public-assistance program, including authorizations for State use of Federal funds for the financing of medical care of the needy through the facilities of the social-insurance system.

HEALTH SECURITY THROUGH SOCIAL INSURANCE

Before turning to some specific comments on the bills under consideration, I want to include at this point some general remarks about the use of the prepayment principle to achieve protection against medical costs. Mr. Altmeyer stated our views on this subject, in some detail, at last year's hearings; I believe a brief summary, adapted from his testimony, will provide some useful benchmarks for my subsequent remarks.

First, let me point out that the experience of the Social Security Board, and of its successor the Social Security Administration, through nearly 12 years of administration has vindicated the soundness of the social-insurance approach to economic security. That experience has reinforced the basic policy, which goes back to the beginnings of our social-security legislation, to place main reliance for the long run upon social insurance as a sound and stable basis for social security, so that public assistance—which is a necessary supplement—will to the maximum extent practicable become reduced to a minimum by the protections afforded through an expanding and maturing system of social insurance.

The Administrator has already pointed out that until a few years ago there were sharp differences of opinion as to the needs of this Nation for health security. The testimony presented last year in the hearings on S. 1606 and that which has

arings indi-
ps that we
go beyond
meet many
f budgeting
differences
should be
sponsored
ry, Nation-
.

d for some
nly a few
be termed
gest enroll-
Blue Cross
st 10 years,
ted States.
ticularly in
ship is very
ulation had
strated, on
the middle-
at difficulty
s. In gen-
rotection—
and facili-

plans are
nt medical-
rollment of

During the war years there was a rapid increase in commercial group insurance through which employees are reimbursed in cash for all or a portion of their hospital and medical fees (principally surgical). Policies of this type formerly covered only employees, but recently the coverage in many instances has been extended to employees' dependents. Last year, 8 or 9 million persons had contracts for hospitalization indemnity payments; of this number about 6 million were also eligible for surgical indemnities. Although this provides some protection, insurance of this type is not a satisfactory substitute for comprehensive insurance protection. Both the number of persons served and the benefits received are too limited

In addition, many people have contracts for limited indemnification of medical costs under individual commercial insurance policies (industrial life, accident, and health, etc.) ; but the total number is not known reliably and the amount or scope of protection against medical costs is small relative to the national need.

Judged by the population it covers and by the scope of the protection it provides, as against national needs, the achievements of voluntary insurance are small. This failure is not due to lack of effort, earnestness, or skill on the port of individuals or organizations sponsoring those programs; nor, as appears from public opinion polls and other evidence, is it the result of lack of interest on the part of the American people. The rapid enrollment of Blue Cross and medical-society plans in many places indicates that even the restricted protection offered by these plans is welcomed by the public.

The limited accomplishment of voluntary insurance is probably mainly due to the fact that the task is too large and too difficult to be accomplished by organizations or associations representing only a portion—and in most instances a very small portion—of the public. No type of voluntary plan for comprehensive services—alone and unaided by governmental effort or funds—has ever even approximated, either here or abroad, the goal of including all of the population in a region. As a rule, those who are most in need of protection, especially by reason of low or uncertain income—are not covered. Voluntary insurance is necessarily expensive or restricted, because it is constantly exposed to an adverse selection of risk among those who enroll or stay enrolled. Experience the world over has shown that only through government action can large-scale or complete coverage be achieved. It is, of course, conceivable that American experience might prove the exception, but general experience makes this unlikely, and those who advocate this possibility are in effect pitting their guesses or hopes against experience. It might be noted that a number of representatives of voluntary insurance plans who have testified have in effect admitted this, and they have suggested public subsidy to support the coverage of low-income groups. Their suggestion raises the complex questions involved in the transfer of public funds to private agencies.

The economic and social reasons why voluntary programs have not succeeded, and are not likely to succeed, have been expressed on at least two occasions by the American Medical Association.[4]

Experience persuades us that a comprehensive health-insurance program must rest on a method of financing which makes it possible for families to budget the costs in accordance with ability to pay. These costs are held to a minimum through broad and compulsory coverage, avoiding the financial and related problems of adverse selection. Perhaps the greatest value of voluntary health insurance has been the experience gained in learning how to operate compulsory health insurance.

A national system of health insurance.—In order to be altogether adequate and successful, health insurance must make it possible for everybody to have ready access to adequate medical care, both preventive and curative. If this cannot be achieved from the outset, the program that is adopted should lend itself to growth, with comprehensive services and national coverage as the goal. To the greatest extent practicable, care should be provided for the dependents of insured workers on the same basis as for the worker. As far as is practical, the insurance program should be extended by supplementary agreements or otherwise to cover all noninsured groups who are in need of protection. All existing medical personnel and facilities meeting reasonable standards that wish to participate should be utilized to the maximum degree, and the remuner-

---

[4] Medical Care for the American People. Chicago, 1932. Minority Report No. 1, Committee on the Costs of Medical Care (approved by the house of delegates, AMA), pp. 163, 164; A Critical Analysis of Sickness Insurance, bureau of medical economics, AMA, Chicago, 1938, p. 22.

ot be sacri-
ient should
blic, should
o be made
isease and

d facilities
umber and
minimum
ourage the
The cost
population.
regardless
e is in need

-repayment

vitness the
eluctant to
e practical
he efficient,
ance is to
centralized

he Agency
our testi-
nt only to

adapted to the financial resources of the States. Great care must be taken not to create, within States, undesirable competitive financial situations among grant-in-aid programs. This is an important reason for our efforts toward uniform or rationally related Federal-aid provisions in different grant-in-aid programs. The same kind of reasoning supports a number of other objections, cited in our report on the bill, against lack of certain administrative standards, excessive controls lodged in special professional groups, insufficient controls over public funds that may be paid out to private organizations, and the absence of safeguards for the rights of persons to be aided by the program and of those desirous of providing services under it.

In light of Mr. Altmeyer's testimony of last year and the opinions I have expressed, we commend S. 1320 to your favorable consideration. As indicated in our report on this bill, we think its provisions show considerable improvements at many points over those that were contained in S. 1606 (79th Cong.) which we also recommended favorably.

The Social Security Administration concurs in the comments which the Administrator of the Agency and the Surgeon General of the Public Health Service have already made with respect to the declaration of purpose (title I) and the development and expansion of community-health services (title III).

The Administration particularly commends the system of prepaid personal health service benefits contemplated by title II. We believe that the present bill is sound and realistic in its positive provisions, in recognizing and taking into account limitations in benefits that may have to be made in the first years of operation, in providing time for the "tooling up" period, in lodging very broad administrative responsibilities and discretions in the States, and in providing for coordination of the administration of health programs at Federal and State levels, and for coordination of health and social-security programs at the Federal level. Administration of the system should turn out to be practical and administrative costs moderate. Certainly, administration will not require anything like the fantastically large staffs estimated by some critics of the bill. The broadening of coverage (over that in S. 1606) by inclusion of Federal employees is sound, since we believe coverage should be as broad as practical. We think that the combination of national assumption of obligations and national financing, on the one hand, with decentralized Federal-State administration, on the other, is well designed to meet a Nation-wide problem and yet take account of diverse needs and circumstances.

We have not completed our studies of the costs and financing of S. 1320. Since the costs are likely to be similar to those which we estimated for S. 1606 last year, we refer to our earlier testimony on this point as giving approximate guides. The financial provisions appear to be approximately adequate. As was the case for S. 1606, the financing of S. 1320 would call for separate legislation, involving decisions as to the allocation of costs among the persons to be insured, their employers, and general revenues. We assume that such decisions would be made with full regard for social-insurance finances as a whole and for general tax and fiscal policies.

CONCLUSION

While we endorse the objective of S. 545 to make medical, hospital, dental, and public-health services available to every individual, we cannot subscribe to many of its specific proposals or specifications. We think it would be regrettable to make provision for health services for needy and near-needy persons only, except as a means of strengthening the public-assistance programs, while failing to make provisions for the self-supporting population that also needs help in obtaining more and better health services. If only a fractional program is to be considered favorably by the committee, we hope it will consider some of the alternatives mentioned in our Agency report of S. 545.

We support S. 1320 both for its comprehensive objectives and provisions. We think it proposes in sound ways to stake out the interest of the United States in the health of the population and to indicate the readiness of the Federal Government to help toward health progress. It would give substantial and needed aid for community-health services, and it would build a national social-insurance system for prepayment of medical costs—a system that could give most of the population increased access to such services while at the same time greatly relieving them of burdensome costs.

n history,
m for the
n of public
r medical
gh a com-
of wages

decades in
years of
d of com-
and is at-
affecting
tion, case-
ust largely
generative
sease, the
ore nearly
at cannot
g needless
lth there-
Hence the
ady access

aces now
creasing—

cost of treatment for work-connected injuries, and most of them do so through insurance. Workmen's compensation, under which about $150,000,000 was spent for medical care in 1945, is the only prepayment plan in the country covering any substantial group of workers on a compulsory basis. The prepayment principle has also been used in a number of voluntary medical-care plans. The principal limitations of such voluntary plans have been inadequacy of coverage, restrictions on services, limitations on membership, inability to adjust contributions to income, and relatively high costs.

In June 1946, about 21.7 million persons, or 15.7 percent of the civilian population, were members of Blue Cross plans, which provide for prepayment of hospitalization costs. About 6,000,000 persons were subscribers to voluntary prepayment plans under medical society, private group clinic, consumer, employer, and Government auspices. About one-third of them, primarily Blue Cross members, were eligible only for surgical care in a hospital; the others were entitled to relatively complete service. Another 8 or 9 million persons, including dependents, were covered for all or part of this hospitalization costs through group policies issued by commercial insurance companies; group policies to indemnify surgical costs also were in force for about 6,000,000 of these persons and their dependents. Several million individuals—the exact number is not known—held personal health or accident policies issued by commercial insurance companies.

Federal, State, and local governments have assumed some responsibility for the care of certain groups in the population. The Federal Government provides medical care of varying degrees of completeness for members of the armed forces, merchant seamen, and some veterans. The Federal Government also furnishes treatment for work-connected disabilities sustained by its employees, pays for maternity and infant care services received by wives and children of enlisted men in the armed forces, and maintains institutions for persons afflicted with leprosy. Institutional care of persons suffering from tuberculosis and from mental disease or deficiency is generally a State responsibility. Local units of government provide most of the hospital care given persons with communicable diseases. State and local governments share in varying proportions the cost of medical care to the needy sick. All three levels of government contribute toward programs for maternal and child health and services for crippled children.

In the fiscal year 1944–45, expenditures to carry out governmental health and medical functions amounted to more than $1,000,000,000, excluding care of members of the armed forces but including care of veterans and public-health services. Tax funds, in other words, provided about 1 dollar in 5 of the Nation's total health bill. Of the governmental dollar, about 32 cents came from the Federal Treasury and about 68 cents from State and local resources.

There is general agreement on the desirability of a larger governmental contribution to the cost of keeping the Nation in good health; the only major differences of opinion are on the most appropriate way of making it. Some suggest that it should take the form of more free care to needy persons and to persons of low income. Although, by and large, the medical care of needy persons is undoubtedly insufficient and more ample provision should be made for that purpose, free care on a means-test basis is not the solution to the problem faced by the great majority of normally self-supporting persons. Such persons can and would prefer to pay for their medical care through some system of prepayment that distributes medical costs over groups of people and periods of time, rather than seek free care after they have been reduced to dependency. Experience both here and abroad indicates the effectiveness of achieving this objective through a health-insurance program under governmental auspices, financed out of periodic contributions by employers and employees. Extension of governmental responsibility for the Nation's medical services, the Board believes, can best be effected through a program of this type.

Such a program, it should be understood clearly, does not represent socialized medicine but is a method of insurance payment. Through it, families that are ordinarily self-supporting make small regular contributions to a fund from which payments are made to doctors, hospitals, and others for care rendered to them as insured patients. Persons dependent on public funds can be covered through payment to the insurance system of contributions on their behalf, and thus can receive medical care just as others in the community receive it, without the stigma and inadequacy often associated with "poor law medicine."

With assurance that their bills for needed services will be paid from the fund to which they have contributed, insured persons can be free to seek medical advice

e greatest.
o elect to
ors should
ors should
from the
f patients,
f the cost
it would
vices best
l be more
improving
xtend the
kness and
assurance
uld make
better use

ctive basis
establish
and local
iency and
nd use of
ndividuals
national
arrange-
ned. The
e designed
regard for
le for the
or medical

In addition, the Social Security Administration has a broad responsibility under law for—

> studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment, compensation, and related matters. (Social Security Act, Sec. 702).

Ever since 1935, when the Social Security Act became law, the Social Security Board and its successor the Social Security Administration have undertaken to carry out its responsibilities and obligations under this provision of law. It has drawn upon its facilities, including the experience of its program bureaus and the studies made by its research bureau, to determine the areas of economic insecurity in which no provisions have been made or in which the provisions are found to be inadequate, to measure and define the existing needs, and to develop recommendations on the basis of carefully worked out plans.

PRIOR SOCIAL SECURITY BOARD RECOMMENDATIONS

Our administrative and research experience, and that of other agencies working in this field in the last decade, have confirmed beyond all doubt the opinions, now widely held, that health is basic to the security of the individuals and families that make up our population, and that health services should be made more adequate and more readily available to our population than they are now. Mr. Altmeyer summarized our opinion as follows, when testifying before the Committee on Education and Labor last year:

> The lack of adequate measures to cope with sickness and with sickness costs constitutes the most serious gap in provisions for social security in the United States. This lack affects all areas in the country, all age groups, and nearly all income levels. Of course we should strengthen our public-health programs in order to prevent all illness and disability that is preventable. But since most illness and most disability cannot yet be prevented, steps must be taken to make adequate medical care more accessible to all. The most practical method of working toward this goal is to distribute medical costs among large groups of people and over a period of time. (Hearings on S. 1606, 79th Cong., p. 172).

The conclusions of the Administration are the result of several years of deliberation and study. The Social Security Board, the predecessor of the Administration, by unanimous action of its members has formally recommended, each year since 1938, the use of social insurance techniques as a protection against the economic insecurities arising from sickness and disability. We are still of the conviction that the inadequacy of health provisions and the inadequacy of social security provisions against sickness remain among the most serious threats to economic security in this country.

A program for security against the costs and losses caused by sickness impresses us as being inherently both a social-security program and a health program. I would not wish to minimize one or the other. A sound program is one that would deal with both coordinately. Moreover, as we appraise existing needs it is self evident that they will not be met by a health program restricted to needy persons. People normally self-supporting must likewise have protection.

GENERAL RECOMMENDATIONS OF THE SOCIAL SECURITY ADMINISTRATION

Since Commissioner Altmeyer testified comprehensively at the Senate hearings last year, and his testimony is available in the published

grounds
aterially
anged in
increased
ted prac-
ne enact-
hospital
lities.
tive pro-
dered in
y. They

s.
lequately
does not
ating in-
hildren's
mention
tive pro-
an effec-
and for

Federal aid should be made more generous to the relatively poor States.

Senator SMITH. I think in S. 545 we tried to make those distinctions.

Mr. MITCHELL. After the allotment is made, the State, as I understand it, must put up dollar for dollar for the funds it actually gets; whereas, we would recommend what we call a variable grant formula whereby the money that actually goes to the States is not on a dollar-for-dollar basis, but the poorer States would get more than $1 for the dollar they put up.

Senator SMITH. I think that under our program the thing is worked out percentagewise, as I recall our plan. We have the educational bill, and I thought in both this bill and the educational bill we recognized that the State would pay 25 percent in some cases and more than that in other cases.

Mr. MITCHELL. I wish anyone would correct me who knows the answer, but I think I have the correct answer, that in making up the formula for allotment to the States S. 545 takes into account population and fiscal capacity of the States, but that formula only determines the amount available to the State which it will match dollar for dollar. There are States which don't have that many dollars. We propose that once the allotment is worked out, the States would have to put up money inversely in relation to their wealth.

Senator SMITH. That is a problem we will develop. We are working that out in connection with the educational bill as well, and I imagine we can work out a similar plan in both cases. Mr. Cornell tells me your general idea is correct as far as this bill is concerned. I agree with you there ought to be a differentiation of some sort.

Mr. MITCHELL. The present laws treat medical care in the same way as other necessities such as food and shelter. Federal sharing is now limited to payments to needy persons up to specified amounts. States now use various methods to provide medical services to recipients; some States make payments to recipients, and often exceed the Federal sharing limits; some pay direct to the practitioner or hospital providing the case, without Federal funds; others use both methods. There is an important and widely recognized need that the Federal law should give more flexibility to the States to enable public-assistance agencies to use either or both of these methods with Federal financial aid.

I believe I might interpolate at this point that there is before the Congress at the present time a bill called the Cooper-Forand bill that would undertake to correct some of the difficulties that I am referring to here.

In any case any legislation in this area should take fully into account the interrelation between health provisions for the needy and other general provisions for them. In calculating public-assistance benefits the States are required to give consideration both to resources and to need—including health needs. If medical care is provided under health programs separate from assistance, coordination between the two is imperative lest there be gaps or overlaps which would cause both welfare and health programs to suffer.

The fourth and largest area to which I would like to invite your attention concerns the economic insecurity experienced by normally self-supporting families which is caused by the costs of medical care.

ience in
early to
ese ordi-
pointed
otection.
ely to a
nsurance
to be a
otection.

uld like
a basic
his quite
ummary.
e had in
dence of
s tended
security
in upon
Public
, but its
e of the
stem of

Voluntary plans offering service benefits have enrolled perhaps between 7 and 8 million persons—5 to 6 percent of the population. The protection afforded differs greatly. In some, benefits are restricted to certain age or income groups and others exclude costs of servicing preexisting disabilities.

Despite the earlier objections of the American Medical Association to all forms of health insurance, about two-thirds of the 7 to 8 million persons covered by medical care plans that provide service benefits are covered by plans sponsored by State and county medical societies. The American Medical Association now favors voluntary health insurance when sponsored by the State or local societies. Again, these plans for the most part are limited to catastrophic illness. They are expensive and customarily permit extra charges if the insured has income beyond a specified amount. Quite a few of these medical society plans provide only limited indemnity payments—not service benefits—and the trend may be in this direction.

I am informed that commercial group insurance has been extended in the past few years to cover some 8 to 9 million persons for all or a portion of their hospital fees. About 6,000,000 of them are also eligible for surgical indemnities. In addition, many people have commercial individual insurance policies providing limited indemnification of medical costs, but the number covered and the protection provided is very small in relation to the national need.

No type of voluntary plan for comprehensive services—alone and unaided by governmental effort or funds—has ever even approximated, either here or abroad, the goal of including all of the population in a region. As a rule, those who are most in need of protection—especially low-income groups—do not get it. The accomplishments of voluntary insurance have doubtless also been limited by the fact that it is expensive and restricted. This is necessarily so because it is customarily exposed to an adverse selection of risk. I am informed that even some of those favorably disposed toward voluntary insurance plans have testified that universal coverage under them cannot be achieved. They have suggested public subsidies to support the coverage of low-income groups. To do so would, of course, raise a whole new set of complex questions.

A NATIONAL SYSTEM OF HEALTH INSURANCE

Experience persuades us that a comprehensive health-insurance program must rest on a method of financing——

Senator DONNELL. Pardon me, Mr. Mitchell. I notice in your statement here you have something which reads as follows:

> The economic and social reasons why voluntary programs have not succeeded and are not likely to succeed is that they have been prevented on two occasions by the American Medical Association.

Do you mean to delete that or are you leaving that in?

Mr. MITCHELL. That is true, as indicated in my lengthy statement. What I am reading here is a very considerable summarization of that longer statement.

Senator MURRAY. The full statement is going in the record?

Mr. MITCHELL. I hope so.

Senator SMITH. Yes; that is included in the record.

Senator DONNELL. You are leaving the full statement in?

families
ese costs
e, avoid-
We feel
possible
re, both
e find it
the pro-
ke to see
me basis
re high-
reason-
h as to
patient
s well as
adequate
research,

hysician
impor-

and administration would be made more complex, and the complexities would occur at a time when simplicity and consistency are more needed than ever before.

We are concerned also about the failure of S. 545 to set out standards such as would establish a sound basis for Federal-State cooperation in the administration of this program. Again we draw upon our experience in the administration of existing Federal-State programs to suggest that administration is improved and program objectives have more likelihood of accomplishment if the rules of the Federal-State relationships are set out clearly in the statute.

Some of the grant-in-aid provisions of S. 545 in our judgment are not well adapted to the needs of the program; equal matching requirements are likely to work a hardship on the relatively poorer States which are the ones most in need of Federal aid. In this respect we would recommed a system of variable grants adapted to the financial resources of the States.

As Federal-State programs of cooperation involving Federal grants-in-aid have become more numerous and have necessitated the appropriation of progressively larger sums of Federal money, the need for uniformity and consistency in Federal policy has become increasingly evident. In fact, Senator Morse sponsored a successful resolution which provided authority to make an investigation of this problem. The Federal aid provisions of S. 545 differ in many respects from similar provisions in going programs and would not in our judgment constitute a sound pattern for guilding further action in this field.

In conclusion, we commend S. 1320 to your favorable consideration. We regard it as a considerable improvement over its predecessor S. 1606, which was introduced in the Seventy-ninth Congress. Title 2, providing personal-health-service benefits through a system of social insurance, is closely related to the established field of actiity of the Social Security Administration. We particularly endorse that title and believe its provisions are sound. We endorse especially the provisions which lodge very broad administrative responsibilities and discretion in the States and those which provide for coordination of the administration of health programs at Federal and State levels and for the coordination of health and social-security programs at the Federal level. We have no hesitation in expressing our judgment that the system can be administered effectively and economically. Certainly, the administration will not require anything like the fantastically large staffs estimated by some critics of the bill. Similar estimates were made by opponents of the original Social Security Act.

The financial provisions of the bill appear to be reasonable and adequate. As was the case in S. 1606, the financing of 1320 will call for separate legislation involving decisions as to the allocation of costs among the persons to be insured, their employers, and general revenues.

While we endorse the objective of S. 545 to make medical, hospital, dental, and public-health services available to every individual, we cannot subscribe to many of its specific provisions or specifications. Except as a means of strengthening existing public-assistance programs, we would regret to see provision for health services restricted to the needy or near needy. The self-supporting portion of our population also needs help in obtaining more and better health services.

Senator Smith. I would like to ask you this question, Mr. Mitchell: Your experience with the social-security programs has been setting up distribu-

ibuting,
bles me.

ut if you
ople are
ponsibil-
service
s the big

t see the
on now.

necessity
y health
think it

endation
t is not
another

program

we are advancing on the broad front in the provision of those facilities and that personnel.

Then, he said, as I understand him, that a year or something like that—possibly more—before we are ready to take on the load, we should be able to anticipate it, and then we should apply the tax principle and begin the payment.

Was that your general idea?

Mr. Mitchell. Yes, sir. As a matter of fact, I have a sentence in my testimony that is just about along those lines:

> Thus the program should be such as to encourage training of personnel and the construction of facilities.

Senator Pepper. But if you build the hospitals to take care of all those people and start training the doctors, unless you devise a better method of getting that medical care through financial ability to acquire it, these hospitals will stand idle and there won't be anybody to use them. They can't pay for them unless the Federal Government money is going to give the service.

Mr. Mitchell. Yes.

Senator Murray. In order to establish a system contemplated under this bill, we have got to start. We have got to first enact a bill and declare what the policy is to be and what the program is to be. Otherwise, if we undertake to wait until more doctors are educated, more hospitals built, they never will be built.

Mr. Mitchell. I strongly agree with that point of view.

Senator Murray. We would be stymied.

Mr. Mitchell. That is right. I don't think that the day of full implementation would be as long off as many people would think because we have already established basic facilities. We have wage records and have developed the techniques of the field organization and have skilled personnel.

Senator Pepper. In other words, you could just add this tax on to the one you are already collecting.

Mr. Mitchell. Even that wouldn't be a complication, except that more people would be covered than are under the present program.

Senator Murray. We have all of the facts available to us with reference to the need and to the fact that we are short of personnel and all that. We know all the facts. What we need now is to develop a program, put it into effect, and follow it up with the necessary provision of taxes and methods of paying for it.

Mr. Mitchell. Yes.

Senator Smith. Mr. Mitchell, if you are willing to stay a few minutes, I want to ask Miss Lenroot if she will give us her little story with a word as to the maternity and children's program.

STATEMENT OF KATHARINE LENROOT, REPRESENTING THE CHILDREN'S BUREAU

Miss Lenroot. I think is is not necessary to comment further on the need, except to stress than the place to begin in building good health among the people is in early childhood because it is in the earliest years of life, naturally, that the foundation for good health is laid. That means beginning before the child is born, in the maternity period.

Dr. Eliot and I gave testimony last year in connection with the hearings on S. 1318 and on S. 1606 with reference to that. The Congress

d child
one for-
d handi-
m.
ely 100,-
ren han-
ic fever,
cts, and

wo bills
ces and
ferences
g or the
also dif-

ience of
rogram.
Bureau,
f mater-
tute the
ncy" has
tal con-
eau and
ners and

The second point that I want to make is that it seems to me very difficult to divide our children into two groups—that is, those economically needy and those not needy. This is true not only because of the reasons stated by earlier witnesses as to the character of the medical need, but also because many parents and children who may not be in economic need would be unable to get access to the kind of comprehensive and well-rounded program that I have outlined unless there were public facilities available.

In my opinion, we shall not succeed in providing optimum opportunity for the children of the United States for health, and certainly no country can afford to do as much to insure the health of its children, unless we are willing to proceed from the point of view of organizing comprehensive community services that will be available to all desiring to take advantage of them, with no economic barriers whatever.

As Dr. Parran had compared health and education, I would also stress the importance of a view of medical care and health services for children, which is comparable to that we now have in relation to education. In S. 545 there are two provisions which are exceedingly interesting to us. One is a provision for school health examinations and provision for dental examinations and care of those in need of dental services whose families because of economic need are not able to purchase dental care. These provisions are separate from the provision for general and maternal health services. Experience has shown in the dental programs that it is very wasteful of time, to say nothing of other problems involved, if the dentist only determines that some need exists and if he cannot go ahead and give corrective service.

The same is true with reference to the school-health program. Our chairman is one of the authors of a school-health bill pending before the Senate. The main difficulty with the school-health program in years past is not that we did not try to give examinations, but that defects found in examinations were so frequently not corrected.

Now, as to the administrative provisions. In S. 545 there are two serious problems from our point of view. The first is that the health services are taken out of the Children's Bureau and put in the new health agency. The Children's Bureau since 1912 has stood for a service to the children of the country which takes into account all of the needs of the child and brings to bear upon his needs the social as well as the health services and facilities.

It is our experience that we cannot make as much progress in any aspect of our work if the work is broken up along functional lines as if we keep these services together and have the possibility of relating what is done for the child from a social point of view and also to what is done from the health point of view. It is also vitally important that the services from the health point of view be in the same agency or department of Government which has the educational services.

Senator Smith. There would be coordination with public school work?

Miss Lenroot. Yes.

Senator Smith. Would this be handled from the Federal level or State level through cooperation?

Miss Lenroot. It would be on both. There has been close cooperation between the Office of Education and Children's Bureau, and also close cooperation on the State level.

e enabled

nteresting
under the
nd child-
nd Child
and that
children

have been
is late, I
the Chil-
the State
ings have
hat if the
945 there
500 more

ates with
he States
go.
stion Dr.
al distri-

it and we

being able to take care immediately of minor deficiencies and also where the need exists for extensive dental work.

I also pointed out that the dental care should be associated with a general child-health program.

Senator Donnell. You were referring to being unable to pay the whole cost of such care in accordance with the provisions of this title?

Miss Lenroot. Yes, I was referring to that.

Senator Donnell. I would like to ask Mr. Mitchell a very few questions. Mr. Mitchell, the statement which you have given us this afternoon, was that prepared entirely by yourself?

Mr. Mitchell. No, sir; it was not.

Senator Donnell. Who collaborated in the preparation of that statement?

Mr. Mitchell. Well, staff members of the Children's Bureau and the Bureau of Public Assistance and the Bureau of Research and Statistics.

Senator Donnell. Did Mr. Wilbur Cohen assist you on it?

Mr. Mitchell. He sat in while going over the rough draft. I don't know if he participated in the development of the original draft.

Senator Donnell. Who drew the original draft?

Mr. Mitchell. I think it was the composite effort of several brains including my own.

Senator Donnell. Do you know who provided the major portion of the statements that you have given, whose thought enters into it primarily?

Mr. Mitchell. Well, I would say despite his absence, Mr. Altmeyer's thought enters into it to a very considerable extent because we drew heavily on his testimony of last year.

Senator Donnell. He has been gone about 2 months?

Mr. Mitchell. Longer than that, since about the 1st of March.

Senator Donnell. He didn't actually help in preparing this statement?

Mr. Mitchell. No, sir.

Senator Donnell. Who was it that actually drew the first draft of the statement?

Mr. Mitchell. I frankly don't know.

Senator Donnell. You don't know?

Mr. Mitchell. No, sir.

Senator Donnell. At whose request was it drawn?

Mr. Mitchell. Mine.

Senator Donnell. Whom did you request to draw it?

Mr. Mitchell. I asked Mr. Cohen to arrange to have it done.

Senator Donnell. Mr. Wilbur Cohen?

Mr. Mitchell. Yes, sir.

Senator Donnell. He is here today?

Mr. Mitchell. Yes, sir.

Senator Donnell. He did have it done?

Mr. Mitchell. Yes, sir.

Senator Donnell. Don't you think, Mr. Mitchell, that he had a great deal to do with the preparation of it himself? Didn't he tell you so?

Mr. Mitchell. No; he didn't. Really, as Mr. Miller said this morning, I am not trying to fence. I don't know who has more words in this than anybody else. I know I have quite a few in there myself.

Senator Donnell. Mr. Mitchell, have you studied compulsory health insurance yourself?

pert in

on the

re sure.

compul-

ad read

e a few

ets you

cial Se-

Mr. MITCHELL. No, sir.

Senator DONNELL. You remember the name of the pamphlet by Miss Klem on that subject?

Mr. MITCHELL. No.

Senator DONNELL. Or by Mr. Fisher?

Mr. MITCHELL. Mr. Fisher, I don't recall the exact title, but it was on the New Zealand system.

Senator DONNELL. He has studied the New Zealand situation quite a good deal, hasn't he?

Mr. MITCHELL. Yes.

Senator DONNELL. Is he from New Zealand?

Mr. MITCHELL. No, sir.

Senator DONNELL. Has he been down there?

Mr. MITCHELL. No; he has not. He is probably, so far as I have been able to find out, probably the person in the United States that knows more about the New Zealand system than anybody else, but he has developed his knowledge through literature and through the very considerable assistance he has received from the New Zealand Legation here in town.

Senator DONNELL. Is he here today in this room?

Mr. MITCHELL. I don't think so.

Senator DONNELL. Has he been here today?

Mr. MITCHELL. I have not seen him.

Senator DONNELL. But he has never been down there to New Zealand to go over this subject down there?

Mr. MITCHELL. No.

Senator DONNELL. Has he ever written to the Christian Science Monitor on that subject?

Mr. MITCHELL. I never heard of it.

Senator DONNELL. Do you know that extensive articles have appeared in the Christian Science Monitor dealing with the various aspects of the system in New Zealand? Do you know that?

Mr. MITCHELL. No, sir.

Senator DONNELL. You have not read those articles?

Mr. MITCHELL. Not the Christian Science Monitor.

Senator DONNELL. Have you read the American Medical Association minority report, which is mentioned in your footnote? You say on page 17:

> The economic and social reasons why voluntary programs have not succeeded, and are not likely to succeed, have been expressed on at least two occasions by the American Medical Association.

Mr. MITCHELL. I recall that I did read that some little time ago, but I am not responsible for the notation there and I wouldn't accept the responsibility for discussing that in any detail.

Senator DONNELL. Did Mr. Cohen put that in?

Mr. MITCHELL. I don't know. Mr. Cohen is here and can answer for himself.

Senator DONNELL. You don't know who put it in, but you remember that you have read the American Medical Association minority report; is that right?

Mr. MITCHELL. Yes, I do.

Senator DONNELL. How long has it been since you read it?

Mr. MITCHELL. It has been a considerable time.

Senator DONNELL. Well, why did you undertake to say in here, or whoever put that in, that the minority report set out why voluntary

fact that
ctions to
at phase

kly that
the pro-

o which
te under

ere from
for the
Costs of
page 165:

pelling to
n of every
st amount
and lay-
ndards of
a business
xperience
e yet had
evalent in
xceptions.
n through

Mr. MITCHELL. I didn't have that feeling. I read this with the greatest of care to assure myself I was accurately expressing my own feelings in the matter, as well as expressing what I believe to be the policy of the Social Security Administration and Federal Security Agency.

Senator DONNELL. At the same time, you did not give to the members of the committee the information that in these two cases the American Medical Association, in at least one of them, has set forth these objections to compulsory health insurance at the same time along with the objections to the voluntary insurance? There is nothing like that indicated by this sentence, is there?

Mr. MITCHELL. No, sir.

Senator DONNELL. Now, Mr. Mitchell, who wrote that sentence? You say you didn't write it. Who vouched for that to you? Did Mr. Cohen or Mr. Isidore Falk?

Mr. MITCHELL. Neither of them. The document was prepared by the professional staff, probably a half a dozen people.

Senator DONNELL. I would like to know who is responsible for that sentence. We would like to know.

Mr. MITCHELL. I will be glad to find out.

Senator DONNELL. Can you not tell us now?

Mr. MITCHELL. No, sir; I don't know.

Senator DONNELL. Do you know any of them besides Mr. Cohen?

Mr. MITCHELL. I know Mr. Falk participated.

Senator DONNELL. You know Mr. Cohen and Mr. Falk participated?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. What other persons?

Mr. MITCHELL. I think Miss Larsen of the Children's Bureau; Miss Goodwin or a member of her staff of the Bureau of Public Assistance. Beyond that, I do not know.

Senator DONNELL. Beyond that you do not know. Very well. Mr. Mitchell, you mentioned that you regard the matter of freedom of choice, which is referred to on page 18 in the sentence, "Both physician and patient should be assured freedom of choice," as being quite an important statement.

Mr. MITCHELL. Oh, yes.

Senator DONNELL. And you would regard a system which does not insure freedom of choice both to physician and patient as subject to very serious objections, would you not?

Mr. MITCHELL. I would say so, although I don't set myself up as a qualified witness to discuss the details of the purely medical aspects of this.

Senator DONNELL. You have not studied the bill S. 1320 to determine whether there is an assurance of freedom of choice to physician and patient, have you?

Mr. MITCHELL. Yes, sir; I have gone over it and feel it does.

Senator DONNELL. Have you read the bill?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. All of it?

Mr. MITCHELL. Yes.

Senator DONNELL. Have you read S. 545?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. Who was the author of this supplement that is attached to your statement here from the annual report of the Social Security Board, 1946, pages 439 to 443?

hink, was

asn't the

e.

ing free-

American
referred

rature of

rd to the

e Report.

dinavian

Senator DONNELL. You were in that 4 years?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. You did not finish Georgetown University?

Mr. MITCHELL. I finished for the certificate, which is what I was a candidate for. That is a 2-year course and I finished that.

Senator DONNELL. You received that certificate?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. In what year did you receive that?

Mr. MITCHELL. 1923.

Senator DONNELL. Did you go into the insurance business right after that?

Mr. MITCHELL. No; I was in the insurance business after I got out of high school and then for at least one summer while I was going to college.

Senator DONNELL. So your insurance experience, then, was between the time that you entered high school and the time you left college?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. And the college is Georgetown University, as you have recited?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. What did you do right after you left college?

Mr. MITCHELL. I went with the United States Department of Commerce and I stayed with them for about 11, maybe 12 years, in several capacities. In their offices in New York, Louisville, Norfolk, Atlanta, Ga., and here and was abroad for a short time.

Senator DONNELL. You left the Department of Commerce in what year?

Mr. MITCHELL. I left the Department of Commerce, I think, in 1933 when I became the State Director for the National Recovery Administration in Georgia, and was subsequently made Regional Director for the National Recovery Administration.

Senator SMITH. Would you be kind enough to send a brief statement to the clerk of this committee concerning your subsequent experience after you went to the National Recovery Administration?

Mr. MITCHELL. Yes, sir.

Senator DONNELL. I ask that this be set forth in the record.

Senator SMITH. Very well.

(Subsequently Mr. Mitchell submitted the following memorandum:)

I joined the staff of the United States Department of Commerce in 1923 here in Washington and subsequently served in the district offices of the Department in New York, Louisville, Ky; Norfolk, Va.; and Atlanta, Ga., respectively, as Commercial Agent, Assistant District Manager, and District Manager. Late in 1933 I transferred to the National Recovery Administration where I became State Director for Georgia and subsequently Regional Director for the seven Southeastern States. During this period I also served as State Director for the National Emergency Council.

Early in 1936 shortly after the enactment of the Social Security Act I went with the Social Security Board as Director of the Bureau of Business Management and some 3 years later was made Assistant Executive Director in which position I served until July 1946 when the three-member Board was abolished. In 1941 I was Associate Director in charge of operations of the United States Employment Service, and returned to my position as Assistant Executive Director when the War Manpower Commission was established. In July 1946 I was made Deputy Commissioner for Social Security which is my present capacity although I am serving as Acting Commissioner in the absence of Mr. Altmeyer.

Lenroot.
ss adopts.
adequate
n get the

dequately

ink very
order to

riers such
children

est tends
—that is,

indicate

r in your
nent ago,
er to the
sing vol-

Compulsion was in the mind of whoever wrote that.

Senator MURRAY. It didn't mislead me. I knew that the American Medical Association is against compulsory insurance and I think every member of this committee knows that. I think the people of the country know pretty well that the American Medical Association is opposed to compulsory insurance.

Senator SMITH. If there are no further questions, the committee will adjourn until 9:30 tomorrow morning.

(Whereupon the subcommittee adjourned at 6:10 p. m., to reconvene at 9:30 a. m., Thursday, July 10, 1947.)

E,
D. C.

a. m., in
exander

ay, and

come to
place of
ation of
ard and
Cruik

Mr. Cruikshank. Well, it was prepared in conjunction with a number of people, and a draft was sent to Mr. Woll, which he corrected and made some amendments to, and then sent back, so that it is really his statement.

Senator Donnell. At any rate, it was prepared by a number of people and a draft sent to him, and he made some corrections and sent it back?

Mr. Cruikshank. So that it is his statement.

Senator Donnell. Well, that remains to be seen, of course, whose statement it is, but did you have anything to do with the preparation of it?

Mr. Cruikshank. I had some part in it; yes, sir. I believe he transmitted the copy in accordance with the rules of this committee—transmitted a copy with a covering letter stating it was his statement.

Senator Smith. This telegram from Mr. Woll—I will read it at this point for the record. It is addressed to Mr. Rodgers, clerk of our committee:

> Regret unforeseen circumstances prevent my being in Washington to present testimony on health bills July 10, as scheduled. Am asking Nelson H. Cruikshank, our director of social insurance activities, to present the position of the American Federation of Labor before Senate subcommittee. The statement presented by Mr. Cruikshank will be the same as that forwarded to you with my letter of July 3. Mr. Cruikshank has full authorization to represent position of American Federation of Labor before your committee.
>
> Matthew Woll,
> *Second Vice President, American Federation of Labor.*

Mr. Cruikshank, will you proceed?

Mr. Cruikshank. My name is Nelson H. Cruikshank and I am director of social insurance activities for the American Federation of Labor. I am presenting the following statement at the request of Mr. Matthew Woll, second vice president of the American Federation of Labor and chairman of its social security committee. Mr. Woll regrets that unforeseen circumstances prevent his appearance before your committee this morning. He has asked me to present the following statement on his behalf as representing the approved position of the American Federation of Labor with respect to both Senate bill 1320 and Senate bill 545.

Senator Smith. Might I ask you a question, Mr. Cruikshank? I understand from that telegram—perhaps I read it wrong—that you were chairman of the social security committee of the American Federation of Labor.

Mr. Cruikshank. No, Mr. Chairman.

Senator Smith. Mr. Woll is chairman of the social security committee?

Mr. Cruikshank. Yes, sir.

Senator Smith. And what is your position?

Mr. Cruikshank. Director of social insurance activities, a staff position.

Senator Smith. I see. Proceed.

Mr. Cruikshank. On behalf of the 7½ million men and women who today make up the American Federation of Labor, I am here this morning to support the national health insurance program as proposed in S. 1320 and to register our opposition to the Taft governmental charity bill.

tives of
ny they
untry's
pite the
t their
orward

he dis-
red be-
cal care
luated.
be con-
people

he pro-
shank?

son H.
and so
you go
speak-

is Mr.
over a

surance, which was unanimously adopted by the sixty-fifth convention of the American Federation of Labor held in Chicago, Ill., last October.

(The declaration of the sixty-fifth convention of the American Federation of Labor follows:)

DECLARATION OF THE SIXTY-FIFTH CONVENTION OF THE AMERICAN FEDERATION OF LABOR—SOCIAL INSURANCE (UNANIMOUSLY PASSED AT CHICAGO, ILL., OCTOBER 17, 1946)

The principles embodied in the legislation introduced in the Seventy-ninth Congress pursuant to the declaration of the sixty-fourth convention of the American Federation of Labor (the Wagner-Murray-Dingell bill, S. 1050–H. R. 3293) are reaffirmed. The goal and objective of the American Federation of Labor remains the development of a comprehensive national program of social security for all workers not otherwise covered by an existing program, built upon the solid foundation of contributory social insurance. Such a program must include:

1. A system of insurance providing benefits based on past earnings for the aged, the survivors of deceased workers, and the permanently disabled. These benefits must be sufficient to maintain a decent standard of living without reliance on public or private charity. The coverage of the present program needs to be extended to the remaining 40 percent of workers not now protected, and the age of retirement should be lowered by at least 5 years for men and 10 years for women workers.

2. A national system of unemployment insurance providing benefits based on past earnings and with minimum benefits adequate to maintain for even low-income workers a decent standard of living. All involuntarily unemployed workers, including those unemployed by reason of temporary disability, should be eligible. The administration of such program should be the responsibility of the United States Department of Labor.

3. The reestablishment within the United States Department of Labor of an adequate national employment service.

4. A national system of health insurance providing health services to all workers and members of their families. Such a system should be augmented by grants-in-aid to the States out of general revenues of the Federal Government for: (1) The construction of health facilities, (2) training of medical personnel, (3) medical research, (4) expansion of public-health services, and (5) continuing and extending the present program of maternal and child-health services.

5. A unified public-assistance program providing grants-in-aid to the States adjusted to the relative needs of the States in order to provide more equitable assistance to all needy persons.

Your committee recommends that the committee on social security work with the president of the American Federation of Labor in preparing and submitting to the Eightieth Congress legislation designed to meet the above-stated needs and objectives. In the preparation of such legislation special care should be exercised to see that in the development of policies and in administration it provides for full participation of the representatives of the workers covered by the program.

The growing interest in and increasing public support for inclusive health insurance of the kind sponsored by the American Federation of Labor requires that special attention be given this phase of the program. The extensive hearings on the federation's health-insurance bill (S. 1606–H. R. 4730) resulted in a great increase in public understanding of the proposal. The need for some national action in this field is no longer denied by the opposition. The issue now is whether medical care should be extended as a charity and in accordance with public welfare concepts or whether it should be made universally available by an extension of the insurance principle. We reaffirm our unfaltering support of the insurance principle.

Your committee recommends that in addition to the safeguards written into the earlier health-insurance proposals, such as those protecting the right of free choice of physicians, the following provision be included in any health-insurance legislation: (1) A specific requirement that local agencies be given the maximum amount of control possible in the operation of the program, (2) provision for the continued operation of all such existing health programs that can provide suitable medical services, such as those developed by labor organizations, by cooperatives, and by other voluntary groups, and (3) maximum participation in local adminvho repre-

ninth Con-
ate. Your
take steps
ls.
e national
e States to
mployment
State fed-
ur specific
ecommend
1) To free
nployment
is due to
tes where
—only 2 of

who serve
can render
respective
al-security
arrying on
Conference

ernational
with the
pointed in
promotion

1. That the present limitations existing in some States on coverage by the number of employees employed in an establishment or by an employer be removed.
2. That maximum unemployment benefit payments be increased to $25 per week.
3. That the maximum period for which benefits can be paid to eligible workers be raised to 26 weeks.
4. That the restrictive disqualification provisions which prevent workers who are involuntarily separated from their employment from drawing benefits be modified so as to remove the penal provisions from the State unemployment insurance systems and restore the traditional freedom of workers to change their employment.

Mr. CRUIKSHANK. Here are copies of that, Mr. Chairman, if you wish to have them.

This action of the convention is not the first evidence of interest in this subject or of support for the enactment of health insurance. The concern of the American Federation of Labor and its affiliated bodies with matters of health goes back for over 40 years when our State branches began to consider enactment of workmen's compensation laws. We have likewise been vitally interested in the health aspects of the work place and in the living conditions affecting our workers and their families as evidenced by our long struggle in behalf of sanitation laws and for better housing.

In the convention of the American Federation of Labor held in 1938 there was adopted a resolution brought forward by the California State delegates favoring national health insurance. Significantly that same year the Wisconsin federation brought forward a resolution condemning the position of the American Medical Association in opposition to voluntary health insurance plans. Both of these resolutions were adopted by the convention of the American Federation of Labor.

In 1939 again the American Federation of Labor convention adopted a statement submitted by its executive council endorsing national compulsory health insurance.

Again in 1941, 1942, and 1944 the convention adopted resolutions favoring the establishment of a national health-insurance program. There was no convention held in 1945 due to wartime conditions and in 1946 the convention adopted the declaration which I have submitted for the record.

The Taft and Murray bills have this in common: They recognize the great need existing for medical care in our country today. They also recognize that a major reason for inadequate medical care is the people's inability to pay for it. But there the similarity ends.

The Taft bill seeks to meet this need by offering the American people Government charity. In a country that always prided itself on the virtues of independence, and self-reliance, this is, to say the least, a surprising solution. Even though we disagree with Senator Taft's estimates he has asserted that his bill would provide medical care on the basis of proven need to about one-quarter of our population. If we were to accept the American Medical Association's statement made in 1939 that people with incomes under $3,000 cannot afford comprehensive medical care, then the goal of Senator Taft's bill would be to provide medical care through a Government dole to the greater part of our population. Taking into account the decline in the value of the dollar, a $3,000 income in 1939 had the same purchasing power as a $4,500 income today. Applying the AMA estimates to people

rcent of
compre-

olicy of

n-aid. to
to every

rogram
come to
tion can
ng char-
t. of our
solution
Ameri-

essity as
income
ng, and
ntial to
care is
ision to
rtunate
rcent of

Although unpredictable for the individual, it is possible to estimate how much sickness will occur in a given year for the country as a whole. The solution to our problem thus becomes self-evident. Each individual contributes, together with his employer, a small percentage of his income each year into an insurance fund. With the risk spread over a large enough group of people, it is possible to provide comprehensive insurance against the costs of medical care at a reasonable sum for any one family. The fact that doctors and the people alike have accepted the voluntary medical insurance plans is proof that the insurance principle is workable.

The problem then becomes one of leaving medical care to voluntary plans or instituting a national insurance fund. Granted that voluntary plans have recently shown a rapid growth, the fact still remains that less than 3 percent of our people today get anything like comprehensive medical care under such plans. Little, if any, emphasis is placed on preventive care in the majority of voluntary plans available to the public today. Moreover the premium rate charged by voluntary plans for limited services makes the costs of the services received beyond the bounds of what many of our lower income groups can afford to pay. The temptation not to carry insurance or to drop it if one has had a fairly long period of good health leads to an adverse selection of members under voluntary plans. Although voluntary plans can and are playing an important part in our Nation's health program they offer little hope as the final answer to our overall health needs.

Considering how well accepted our social-security program for old age and survivors' insurance is today, I have never been able to understand the furore that is being raised by certain small groups over the proposal that insurance against the costs of medical care be financed by a similar pay-roll tax. Surely the principle of social security is well enough recognized today that charges of "fascism," "socialism," and so forth, can be dismissed as completely irrelevant. In analyzing the criticisms against pay-roll financing of a comprehensive national health-insurance system let the arguments be measured against our other social-security programs of old-age and survivors insurance and unemployment compensation in determining their validity.

In considering other arguments against national insurance, I hardly need point out to this committee that such a label as "socialized medicine" is mischievous and untrue when applied to the Murray bill. One suspects that opponents have deliberately mislabeled S. 1320 in order to turn the public against the bill before it has even had time to consider the bill's provisions. Such tactics are not fair play, and show a fear on the part of opponents to meet the issues of the bill on their merits. Under an insurance system any charge of socialization reveals either a woeful ignorance of the provisions of the bill or a real misunderstanding of the term "socialism."

The criticism that the Murray bill will lead to centralization and bureaucracy is worthy of more consideration. The proponents of the bill were well enough impressed with this danger, as brought out in the hearings last year, that they revised their bill to provide for bill, it is

itle be ad-
, sec. 241.)

h, among
lized ad-
selecting

not at the
n Federal
ent funds
nent com-
of main-
ems from

ent facili-
vide com-
me. This
ictory for
shortages
ors, more
d also re-
get more

Despite the over-all shortage, immediate enactment of a national insurance program could still help to lessen the severity of the doctor shortage in certain areas by bringing about a better distribution of doctors. With 80 to 90 percent of our population able to pay its medical bills through the insurance fund, doctors could then afford to practice in the more isolated and poorer sections of the country. Hospitals, likewise, could be built in those areas, once the people were able to pay their own way. The alternative offered in the Taft bill of subsidizing doctors in economically poor areas is far less satisfactory in that people would still have to depend on charity for whatever medical care they need. It would also prove a perennial drain on the Nation's budget to subsidize these doctors year after year.

Despite the testimony of some doctors before this committee, workers are not satisfied with insurance that covers only their hospital bills and the medical care they receive while in the hospital. Together these two items make up far less than one-half of their total medical bill. Workers want comprehensive coverage, to include preventive, diagnostic, and curative care—without having to worry about the financial cost of keeping healthy. Until we can divorce medical care from the immediate ability to pay we will not have overcome our problem. The Taft bill still places its main emphasis on ability to pay in keeping healthy. The Murray bill offers the practicable alternative of paying insurance and spreading the costs of medical care over a lifetime and among millions of family groups.

Today the principal opponents of a national health insurance system are the spokesmen for the medical profession. This is not to overlook the fact that a number of doctors have declared openly, and many more off the record, their strong support of the Murray bill. Looking at the past record of prepayment plans, to group medicine, and its later reversal of its stand on these issues, perhaps it is not too much to hope that the pressure of public opinion will again bring the leadership of the A. M. A. to see the merits of a compulsory health-insurance system.

We sincerely hope that this will come about. But whether or not it does, we think it unwise if Congress lets the opposition of less than 1 percent of our population stand in the way of what millions of workers earnestly want, namely, a self-respecting method of maintaining their health and that of their families.

Senator SMITH. I think we all agree that, as you said in there, what we are trying to bring about is what they want. The question is, What is the practicable way to do it?

I would like to ask you this question: Suppose a worker in a factory has his pay roll compulsorily reduced by whatever the percentage may be—1, 2, or 3 percent, according to the approximate purpose—what do you visualize he is expected to get for having that taken out of his pay check every week? What is he to get in the way of service? I am not talking about money now. I do not want to get mixed up now the difference between a money return from a man contributing to a social-security fund to a certain degree, and a service. I am asking you now what service will that worker expect to get?

Mr. CRUIKSHANK. That would all depend, sir, on the terms of the legislation under which the pay-roll deduction was made.

Senator SMITH. You are asking for medical coverage. You are saying that the voluntary plans are not adequate. I admit they are

way they
would be
ould give
pain and
a pill. I
We want
e sincerity
o question
practical
lsorily of
certainly
o organize
ng to give
nswer, but
is to give
rantee the

e support,
would be
of course,
vould also
rvice that

seen it in

experiment, and even its law was not operative until after the Federal Government acted.

Senator SMITH. Of course that is a matter of judgment as to the wisest way to deal with it by a method of trial and error.

Mr. CRUIKSHANK. That is a matter of historical fact, the history of our Government, in our Nation, with respect to social legislation. We never had child labor law protection until we had the enactment of the Fair Labor Standards Act.

Senator SMITH. We also had, when the framers framed the Constitution of the United States, a vivid picture of what might happen if the Government controlled everything in the center, and decentralization of authority in Government was one of the principles written into the United States Constitution. We have two conflicting political theories behind those two ideas, one of which has the view that the Federal Government should do everything in the total fields.

I am one of those who believe that we profit by trial and error by the States. They ought to be the ones that undertake it. I am willing to have the Federal Government come in and participate, as S. 545 does, and give grants-in-aid to the States, but I want to say to them: "Your problems are the problems of your States. Now, work that thing out and give us the benefit of your experience." And then let the next State do likewise, and by that process in time we will get a better solution than by having a few people sit down, because they may have theories, and write a complete blueprint for the whole country and put upon the country by compulsion in one complete piece of legislation.

That is the difference that I am trying to argue with you. I am not interested in your attack on the means test, because they are both means tests that way. The pay-roll tax is a tax, and the means test is applied, because those who can pay more, pay more; those who can pay less, pay less. I have no quarrel with that. That is the fundamental principle in all social insurance. I am sure that is all right. I am sure I have no objection to that, but don't call it "insurance." It is not insurance; it is a tax for total coverage.

Mr. CRUIKSHANK. I disagree with you entirely, Senator, for all the history of development of social insurance the world over is of that kind, even in private insurance, a field of insurance that carries workmen's compensation and provides medical care.

Senator SMITH. What I was trying to say is—and I don't want to get into a discussion of insurance principles, because I disagree with you—that pay-roll taxes for any form of insurance are just straight taxes. Those who pay less get just the same treatment as those who pay more, but an insurance principle provides for a premium to cover what the table shows that the cost of doing a certain job is.

Take life insurance, for example. The person gets a certain coverage. Everybody pays exactly the same as the next person, and we don't have the premium based on whether you can pay more or can pay less. This proposal is not a real insurance principle. Any insurance man will tell you that. It is not an insurance principle. I am not quarreling with it except I do not want it to be called an insurance principle and the other called a "means test" when in principle they are just the same.

Mr. CRUIKSHANK. Senator, I should have to respectfully disagree with that opinion for the record, as vigorously as possible, because

the fact
hinge on
ill social
of social
ery defi-
around.
ord—put
g differ-
surance,

want to
roll tax,

at there
Work-
partly in

and not
ir of my
private
an cash

t saying
k of this

Senator SMITH. How many years do you think that would take?

Mr. CRUIKSHANK. That we do not know, but it would have to be worked out constructively with those responsible for the administration of the services—and I emphasize "constructively." It could not be worked out by just name calling.

Senator SMITH. No; let us get away from name calling. I am really trying to get an answer. I am not concerned with your attack on the AMA, nor the attack of the AMA on your position. I do not care anything about that. What I want to get at is just how you would do it. How would you pay for the education of the medical profession to bring them up to the necessary numbers, and for all the hospitals and for all the development of the Public Health Service that Dr. Parran so well advocated yesterday, in the interim period before you begin to collect the money by this tax plan?

Mr. CRUIKSHANK. The bill S. 1320 provides a system of grants-in-aid which is pretty well spelled out in detail. So is the method of payment spelled out. That would depend upon the development of such programs by the doctors themselves, through their advisory committees.

The payment for the construction of hospital facilities and health centers, we think of this bill gearing in very definitely with the Hospital Survey and Construction Act passed by the last Congress.

Senator SMITH. Any bill that we pass will gear in with that, of course.

Mr. CRUIKSHANK. But we pointed out at that time that we felt one of the great deficiencies of that bill taken alone, although we supported it fully, we did point out at that time that one of the deficiencies of the bill was that it required, in its plan of operation, a showing of the ability to continue the operation and payment locally on the part of each of these facilities that were built under an approved State plan, and we pointed out that in some of the areas that needed it most, needed the facilities most, you could not get them because they were the very areas that could not carry on the operation of a hospital program after this facility was built, and a health insurance program would very definitely dovetail right into that and meet that deficiency in the construction program.

Senator SMITH. How long do you figure it would take to get all this national organization set up before we would be justified in compulsorily taking money from all of our workers, and their expectation that they were going to get adequate medical service? How many years would it take?

Mr. CRUIKSHANK. I would not want to venture a guess. I do have this experience, though, that I have usually, in judgments that I have made on matters of that kind—underestimated the ability of this country to meet a need. I confess I was one of those who thought that the President's program in 1941 of 50,000 airplanes a year was fantastic. In 18 months we were turning out 75,000 airplanes a year.

Senator SMITH. I admit all that, but I am still compelled to say that you have different modifications. You had a war condition then, where you have a peace condition now, and you have certain resistances that you must overcome.

Mr. CRUIKSHANK. I think that is very fortunate if that is true, Senator, if we cannot gear facilities and the enterprise and good will

eroically
tuation.
Chief of
the pro-
ntry."
a legiti-
purpose.
ce. I do
d I have
timately
ediately
we have
not do it
predict
Senator
the tax

this bill
ernment
people,
o would
s which

o in the

Mr. Cruikshank. Physicians themselves have appeared before this committee and registered many objections to S. 545, and significantly, some of their outstanding objections are those relating to the very objectives of the programs.

Senator Smith. Well, that is an opinion, of course. Generally speaking, you have two different approaches, and that is what we are trying to get light on. I will not pursue that further. I just wanted to bring out that difference, and I will ask Senator Donnell if he has any questions. I appreciate very much, Mr. Cruikshank, your approach and your support and your answers. I think you have helped clarify what this difference in view is in approaching it in this manner. It has been very valuable to us.

Senator Donnell. Mr. Cruikshank, what study have you personally given to the subject of compulsory health insurance?

Mr. Cruikshank. Senator, I try to be cooperative with the committee, and I will answer your question but in answering it, I should like to say that I do not think it is relevant, because I am not here——

Senator Donnell. If I can interrupt you on that, if there is anything more relevant than that, I would not know what it is. You come here advising this committee and expressing the views of 7,500,000 people, telling us what we should do and what we should not do, and when I ask you what study you have made of the subject yourself, you tell us it is not relevant. Of course, you will answer this question.

Mr. Cruikshank. If you ask me, sir, as you just have, what is more relevant, I will tell you.

Senator Donnell. Well, the question that is asked you is, What study have you personally give to the subject of compulsory health insurance?

That is a question that is relevant and proper, and you will please answer it.

Mr. Cruikshank. I have been studying and reading various items and articles for the past several years on the matter. I first became acquainted with the matter of social insurance when I was a member of the Governor's mission in the State of Connecticut to set up the old-age and survivors' insurance program, or, as it was then called, the State old-age pension, in 1934.

Senator Donnell. Now, you say you studied items and articles. Have you ever read a book by anybody on the subject of compulsory health insurance in any country in the world?

Mr. Cruikshank. I have read books, yes; and I would be glad to submit the names and authors and publishers of some of those books if you wish.

Senator Donnell. Let us get them right now.

Mr. Cruikshank. I do not recall just the names now.

Senator Donnell. Give us one.

Mr. Cruikshank. It is an irrelevant question, sir. I am here, Mr. Senator, to talk about the thing in which I am most competent, and that is the need and the experience of the people who are members of our unions for health insurance. On that I am expert, and on that I will present the opinions of the American Federation of Labor.

Senator Donnell. I will ask you, sir, if you will tell us the name of one book that you have ever read.

Senator Murray. Mr. Chairman, the witness has answered him and I do not think his question is relevant.

question?

hat I am
ink it is

the CIO
om. He

his room,
on.

men here
witnesses
od, sound
s already
r another
which he

chairman
g here as
., and he
program
vant for
t that he
ask any

as proposed in S. 1320"—if we can't ask him what he knows about that subject, we have certainly arrived at a very useless function of this committee. I not only shall ask him that, but I am going to continue on that line of questioning until I find out whether this witness does know anything about it.

Senator Murray. Let me say for the record now that the witness has already stated very clearly what he knows about compulsory insurance.

Senator Donnell. He hasn't shown very much knowledge of it yet, and I want to find out what he knows.

Senator Murray. That is all right. He has stated what he has read on the subject. He has stated what he knows about it, and he has stated what his experience has been. Now why is it necessary to go any further when he says he does not recall at this moment what particular books he has read, but says he is willing to furnish the committee with a statement containing the books or pamphlets that he has read, if the committee requires it?

Senator Donnell. Mr. Chairman, I respectively submit that the Senator from Montana is too good a lawyer not to realize that we have a right to cross-examine this witness and not to have an ex parte statement filed here 10 days after this hearing, without opportunity for cross-examination.

I renew the question, sir. Can you tell us the name of any book by any author on compulsory health insurance in any country in the world that you have ever read?

Senator Murray. I object to the question on the ground that he has already answered and this is mere repetition, redundant and filling up the record with unnecessary verbiage.

Senator Smith. I will ask the witness to answer Senator Donnell's question.

Mr. Cruikshank. I do not believe that I can. First let me say this, that the Senator's question is not directed to what he stated is his purpose, asking a person——

Senator Donnell. The question that I have asked, Mr. Chairman, does not call for a comment by the witness on the Senator. I am asking him a question as to the name of any book he has ever read.

Mr. Cruikshank. The purpose of the Senator was to find out what I know. Why don't you ask me questions about social problems?

Senator Donnell. I want to say that this witness is not here to admonish this committee. I am asking him a question as to what books he has read. If he can't tell us, let him say so; if he can, let him say so.

Senator Murray. Mr. Chairman, as an American citizen, I submit that this witness is entitled to make a statement of what he understands the question to be, and I think he has a right to make any statement he wishes in connection with this matter, and I do not think he should be interrupted and stopped as he has been here. He should be allowed to complete any statement he wishes to make at any time. He is an American citizen. This is not a star-chamber proceeding.

Senator Smith. I think the witness can make his statement. Go ahead, sir. Make your statement, but I would like to have you answer Senator Donnell's question.

Mr. Cruikshank. I shall address myself to the question, sir; but I should only like to point out that asking a person what he has read is not the way to find out what he knows. I could have brought in—

t in a list
not mean
ial insur-
ks I have

ad?

ndertak-
e cannot

have the
hearings

hese pro-
itizens to
tlemanly,
benefit of
s not de-
o impute
oblems of
he wishes
ce.
s by any
nd.

Senator DONNELL. Approximately?

Mr. CRUIKSHANK. Well, the Ministry, or something like that.

Senator DONNELL. Health Ministry of New Zealand? Any other books?

Mr. CRUIKSHANK. Not that I can list right now. I can send you some. But may I say this, that I have spent a very short time in each land. I have conferred with people in the British Government who were responsible for health-insurance administration and programs. I have contributed to medical journals including the New York Medical Journal, in an article entitled, "What Labor Expects of Medicine."

I have addressed various sections of the American Medical Association. I have addressed various State medical associations in their conventions, and for about 2½ years I was in charge of the administration of the medical-care program here in this country.

Senator DONNELL. Where was that?

Mr. CRUIKSHANK. Under the Farm Security Administration, and Director of Migratory Labor Camp Programs, which also had the responsibility for the administration of a health program.

Senator DONNELL. Have you ever read the book by Mr. I. S. Falk entitled "Security Against Sickness, a Study of Health Insurance"?

Mr. CRUIKSHANK. No, sir.

Senator DONNELL. You have not read that published in 1936 by Doubleday, Doran & Co.? Do you know Mr. Falk?

Mr. CRUIKSHANK. Yes; I know Mr. Falk.

Senator DONNELL. Now, I would like to find out just a little something about your statement.

Senator MURRAY. Before you leave that, Senator, I would like to ask the witness, have you attended the hearings of the Senate Committee on Health Insurance at different times?

Mr. CRUIKSHANK. Yes, sir.

Senator MURRAY. Have you read the testimony in the record of the many witnesses?

Mr. CRUIKSHANK. Oh, yes; I read the complete record of the hearings of this year.

Senator MURRAY. Have you access to the American Medical Journal?

Mr. CRUIKSHANK. Yes; I have read it.

Senator MURRAY. You have read those articles on compulsory insurance?

Mr. CRUIKSHANK. Yes, sir.

Senator MURRAY. And they have helped you to form an opinion?

Mr. CRUIKSHANK. Yes, sir.

Senator MURRAY. That is all.

Senator DONNELL. Mr. Cruikshank, in regard to this statement, I just want to find out just who it is that really is responsible for the statement which you have given here this morning.

Mr. CRUIKSHANK. Mr. Matthew Woll is responsible for the statement.

Senator DONNELL. I would like to go into that, please. Who wrote the statement as it was originally drafted?

Mr. CRUIKSHANK. At that point, Senator, I will raise vigorous objection. Let me say this: I have come here with the thought that this committee, as so very kindly explained by the chairman, is a committee that is searching for ways in which it can make recommendations to the Congress as to a means of meeting our admittedly serious health

mitted
rching
iter in
signa-
Labor

you to
e type-
esented
n, say-
s "we."
for the
te with
uestion
ent. I

witness
w Woll
cross-
wledge
t is be-
various
dopted
tement,

question as a Senator of the United States, it becomes your question, and I address myself to it. When Mr. Woll submits this in accordance with the provisions and the rules of your committee over his signature, 72 hours in advance, it becomes his statement.

Senator DONNELL. Mr. Chairman, I asked him this: Who took the first step toward the presentation of this statement? What particular individual took that step? That is the question I asked the witness, and I will ask him to answer it.

Mr. CRUIKSHANK. I hesitate very much to appear discourteous, but as a means of registering my objection to that kind of questioning and to the relevancy of it, I shall not answer until subpenaed by the rules of the committee.

Senator DONNELL. In other words, you decline to answer the question?

Mr. CRUIKSHANK. I do, sir, on the ground of its being irrelevant.

Senator MURRAY. I might add that the statement itself speaks for itself, and it is not necessary to state who took the first step in preparing this statement.

It shows right on the face of it that it is the statement of the American Federation of Labor, and this man comes here is a spokesman, a representative of that organization. I think he should be not humiliated as he has been here.

Senator DONNELL. Mr. Chairman, if there is any humiliation, I see no basis for it. This gentleman has come here to testify. He has presented the statement. He says he has presented it at the request of Mr. Matthew Woll. He says that Mr. Woll has asked him to present the statement in behalf of Mr. Woll. I have asked this witness to tell us who prepared this statement and who took the first step on it. It is perfectly relevant, perfectly proper. This purports to express certain exceedingly important opinions, experiences, observations. The man, woman, or whoever it was who sent it announces that he has never been able to understand certain things, makes criticisms of the American Medical Association, and here we are precluded by the answer of this witness who undertakes to determine the relevancy of questions to ascertain whose views these are.

I am going to ask you some more questions. Did you have anything to do with the preparation of this statement yourself?

Senator MURRAY. I object to that as repetitious.

Senator DONNELL. All right. I will withdraw that question.

Senator MURRAY. It has been asked several times.

Senator DONNELL. I will withdraw it in that form, but I am going to ask you: What part did you have, if any, in the preparation of the statement?

Mr. CRUIKSHANK. I think that is the same question, Senator. Let me say this—not to appear to be hiding behind anything—if there are any parts of this question as to the contents or connotation that you would like to ask me about, I will be glad to address myself to the content of the paper.

Senator DONNELL. I will ask you whether you prepared the third paragraph of this paper?

Mr. CRUIKSHANK. That is exactly the same question, sir.

Senator DONNELL. Mr. Chairman, is this witness here to answer questions, or to tell the committee what questions the committee has her you

he ques-
you are
You are
wer the

I mean

n. I do

mplica-
ication,

s to de-
tion.
ke this.
is as to

d para-
ity.
an Fed-
I think

of an executive secretary of the committee. Certain proposals come up, sometimes certain specific legislation in various forms. We go over them. Certain policies are developed. We make notes on those policies. We do not usually have a stenographic report. Then in regard to certain positions and policies we are directed, I, as director of social-insurance activities, and very often the people who are economists, who are in charge of research and education, sit in on those committees.

We prepare draft statements. They are adopted by the committee. Then they are referred by the committee, as this was, for example, adopted and developed in just that way—referred by the committee to the convention. The convention refers it to a committee.

Senator DONNELL. You are referring now to the resolutions adopted in Chicago?

Mr. CRUIKSHANK. Yes, sir. Then that is referred to a committee on resolutions, who report favorably or unfavorably upon it. It is discussed from the floor and then passed much as any other democratic organization.

Now, when it comes to the preparation of a thing like this, Mr. Woll, being an elected official and in a policy-making position in the American Federation of Labor, in two capacities, second vice president and chairman of the social security committee, is informed by telephone from Mr. Green that he is asked to appear. Mr. Woll writes or calls or telegraphs us and asks if our various offices—in this case, my office—if we will prepare something which he can look over in time for him to look at it. I get in touch with our research offices, and we have a little meeting. We discuss certain policies. We start with this.

Senator DONNELL. By "this" you mean the resolution adopted at the Chicago meeting?

Mr. CRUIKSHANK. Yes. We recognize that we had to make the statement for Mr. Woll in line with the adopted policy of the American Federation of Labor. Certain parts of it are given over to certain people. They are brought back. They are geared together. They are placed side by side. The grammatical construction and so forth are tempered in the best of our ability to make them presentable, and when we finally get it to the point where I, or the director of research, go over it—which, in this case we both did—it is then forwarded to the person who makes the declaration, makes the statement. He makes such amendment or changes as he considers necessary. He sends it back. It is duplicated and mimeographed in our office, and he signs it and it becomes his statement when he signs it.

Senator DONNELL. If I may interrupt you, who is the director to whom you referred a moment ago?

Mr. CRUIKSHANK. Research and education, Miss Thorne. Now, we all participated in this thing, and Mr. Woll participated in it.

Now, the detail as to who prepared a certain paragraph, that would be almost impossible to say, because they are mulled over and rehashed and revised, and developed in kind of a group consultative process.

Senator DONNELL. I think that is a very helpful and courteous response and it gives us a clear idea of how it is done.

May I ask you—you said earlier in your testimony, in response to one of my questions early this morning, that there were five or six persons who cooperated in the preparation of this statement.

name?
re my-
fferent

of the

r state-
s state-
us.
sons.
em be-
out in

ow Ida

Falk, is

s state-

ur own

hington

> As against the Wagner-Murray-Dingell approach as a contributory insurance plan, the Taft bill approaches to the problem of providing medical care are through selective public charity.
>
> The second contrast I would draw between them is that the Wagner-Murray-Dingell bill has a national approach, the use of State and local administrative agencies for the administration of a system which is basically national. The Taft bill provides a basically Federal-State approach.

Did you read that portion of those proceedings?

Mr. Cruikshank. I believe I did; yes, sir.

Senator Donnell. And you know, as a matter of fact, do you. from your study of the proceedings of that conference held on December 10 and December 11, which was issued in a booklet for use of members of the Labor Research Group and Staff of the Social Security Administration, not for general distribution, bearig this title, "Summary of Proceedings of the Conference of the Labor Research Group, December 10 and December 11, 1946, Federal Security Agency, Social Security Administration, Bureau of Research and Statistics"—you know that that document, the primary text that runs through it is opposition to S. 545 and advocacy of S. 1320, and that most of these proceedings relate to compulsory health insurance? You know that, do you not?

Mr. Cruikshank. I did not detect that as I read it.

Senator Donnell. You did not?

Mr. Cruikshank. No, sir. I looked at it as an analysis of bills. I know that the Social Security Administration is directed by Congress to make a continuing study of the extension of our social insurance system.

That was a compromise that went back to 1935, when social security was first ventured into by this country, and a recognition that we were not going as far in the development of a social security program as other agencies have, and therefore we gave this agency responsibility for continuing study in this field.

Now, if they had not continued the study of various proposals, they would not have been carrying out the mandate of Congress.

Senator Donnell. Mr. Falk, you know, is with the Bureau of Research and Statistics of the Social Security Administration?

Mr. Cruikshank. Yes, sir.

Senator Donnell. Do you regard the provisions of S. 1320 in regard to the free choice of physicians by a patient as an improvement over S. 1606 in that regard?

Mr. Cruikshank. Well, I think it spells it out further. Let me go back again to the statement which I submitted for the record and from which I quoted this morning, and call to your attention the third paragraph on page 2. This is the declaration of the American Federation of Labor:

> Your committee recommends that, in addition to the safeguards written into earlier health-insurance proposals, such as those protecting the right of free choice of physicians, the following provision be included.

Senator Smith. May I ask you where you are reading that?

Mr. Cruikshank. Beginning with the third paragraph on page 2 of the declaration.

Senator Donnell. The statement made in Chicago.

Senator Smith. That is this resolution. I have the wrong document. I see it now.

ee choice
ng pro-

n amount
the con-
e suitable
peratives,
adminis-
ho repre-

S. 1320
endation
cause if
be in a
e of the
ct those
the free

that the
ragraph
ings, re-
over and

legislation of this type are revealed in the several reports mentioned earlier in this paper. A brief summary follows:

(1) Passage of compulsory sickness insurance legislation would be an entering wedge into the field of compulsory budgeting of personal expenditures and would amount to "an infringement on an individual's liberty."

(2) During the present emergency people have been encouraged to buy war bonds, thus building up cash reserves, and there should be relatively few who will be unable to care for themselves for some time to come after the war.

(3) In spite of much employment and higher incomes, the burden of taxation is already so great that both workers and employers can ill afford to pay for additional insurance.

(4) Group insurance plans between employers and employees and private hospitalization plans especially designed for the low and middle income groups have developed at a phenomenal rate, thus lessening the need for compulsory insurance.

(5) State legislation may be retarded in some States because of uncertainty concerning possible Government centralization of all types of social insurance including a new Federal program of permanent and temporary disability.

On the whole, it appears then, that although more States are becoming cognizant of the possibility of compulsory sickness insurance as a means of protecting individuals who become ill or temporarily disabled, most State legislatures have as yet been hesitant to take positive action.

I call attention to the fact that this is issued by the United States Government Printing Office, Washington, 1946, and on the inner flyleaf appear this words—

Federal Security Agency, United States Public Health Service, Thomas Parran, Surgeon General, Division of Public Health Methods; G. St. J. Perrott, Chief of Division, United States Government Printing Office, Washington, 1946. For sale by the Superintendent of Documents, United States Government Printing Office, Washington, D. C. 25. Price, 5 cents.

Mr. Cruikshank, I observe among others mentioned there by Miss Stuke, the statement that the burden of taxation is already so great that both workers and employers can ill afford to pay for additional insurance. Have you studied the probable cost of placing S. 1320 into effect?

Mr. CRUIKSHANK. Well, I have made some study of that. As a matter of fact, last year we introduced into the record in the hearings on S. 1606 quite a complete study of the cost, anticipated cost, and I assisted in the preparation of that study.

Senator DONNELL. I take it—if I am wrong, please correct me—that you would agree that it is not, in your judgment, likely that the amount of the total cost would be derived from the pay-roll tax alone? In other words, I take it you would agree that, in addition to the payroll tax, there would be a contribution made from the general revenue of the United States Government?

Mr. CRUIKSHANK. Yes, sir; that is our position.

Senator DONNELL. For instance, I note in the publication which Dr. Shearon has just handed me, and which was issued by the American Enterprise Association, proposal for health, old-age and unemployment insurance, a comparison with 1943 and 1945, and back here in an article by Earl E. Muntz appears this sentence near the close of it on page 64:

The social security program, as set up in this bill would require a Federal subsidy based on the most conservative estimates, in excess of 50 percent of the total annual expenditures.

May I ask you, Mr. Cruikshank, whether or not your study would enable you to express an opinion as to the correctness of the percentage therein mentioned?

to use a
resented
es. We
l of the
.

much of
the op-
it as if
or other
ner, and

od Book
is fulfill
are not
ntations,
al costs,

at posi-

I mean

nk, that

Mr. Cruikshank. I will be glad to do that.

Senator Smith. If you have a revised version of that same study.

Senator Donnell. I can join in that suggestion, which I think is an excellent suggestion and I am very glad to have it. Do you recall, Mr. Cruikshank, who it was that presented evidence on this, whether it was you personally or someone else?

Mr. Cruikshank. Mr. Green testified, and he was asked the question. I accompanied him as consultant when he testified. He was asked the question on cross-examination, and he made some general statement and then offered to file an analysis of cost, which he did.

Senator Donnell. That is what you referred to?

Mr. Cruikshank. Yes, sir.

Senator Donnell. Thank you very much, Mr. Cruikshank.

Senator Smith. Just one more question. I hope that in this revised statement, if you file one, you will bring out for us—I would like to know your estimate of the over-all cost, and I agree with you it is probably being paid today, a good part of it, but your theory is to change the instance of the cost from this group to this group, so that everybody bears the expense of taking care of this over-all health need?

Mr. Cruikshank. That is right, sir.

Senator Smith. I would like you to show in your figures what you think that total cost—how much of it you think could properly be borne by the compulsion pay roll tax reduction, and how much could be borne out of general taxation. Those are differences I would like very much to see.

Mr. Cruikshank. However, in any comparison we have to point out that there are a great many hidden costs. There are the unmeasured costs of the lack of preventive care, for example, because I do not think it is ever possible to determine them. There are other hidden costs that might be dug out. They are contained in specific, individual cases.

For example, there are a number of cases that I have known of where people in emergency cases have had to go to the hospital, and they are kept waiting at the entrance office, the admission office of the hospital, and sometimes they are kept waiting where there are internal hemorrhages or an appendix about to burst, or something very serious. We had a fellow here not long ago who fell off a truck and was hit. He was not admitted into the hospital. He was put into the broom closet of the hospital, so he would not be on the records of the hospital because he lacked identification. His coat was on the truck from which he had been knocked, was picked up off the sheet, no identification was on him, and they did not know who would pay the bill, so for about 24 hours he was left in the broom closet of the hospital.

Senator Smith. Where was that?

Mr. Cruikshank. New York—that is a little bit off the subject—but the point I am making is that many times people are kept waiting in the admission office, the outer office of the hospital, until it is determined who is going to pay for the bill. Sometimes it is at night, but the fellow has to go out and mortgage his automobile or mortgage his household goods or go to a loan shark, and I know case after case where people are paying 36 percent a year interest on bills, hospital bills, and some of them have been paying them now for 8 or 9 years, and have paid back the principal several times, for some hospital bill that they had to meet in an emergency. That is the cost of medical care under the present system but it does not show up in the figures.

e a book
low that
ne things
t I have
cy cases,
I would

e I know
to have

I know.
e. Nat-
eful that
o be fol-

that?
you will
w York,
l like to
done. I

f people
hat line.

of years, and this doctor had been unable to receive pay for his services, and naturally, he could not remain any longer.

That condition of affairs can be found in many sections of this country. I think every witness who has come here has testified that the doctors have tried to do the best they could. They have been very wonderful in giving assistance to unfortunate people who are hit with sickness suddenly or have an accident, and so forth, but there is a limit to which they can go. It seems to me that it is no reflection on the medical profession to have a bill of this kind introduced. Nevertheless the American Medical Association has always taken the position that there was no great problem in this country. They even opposed voluntary insurance to start with, and it is only in recent times that they have come to recognize that there is a problem. At first, they contended that there was no problem at all. Is not that true?

Mr. CRUIKSHANK. Yes, sir.

Senator DONNELL. Just for convenience in cross-reference, my attention has been called by Dr. Shearon to the fact that in the letter from Mr. Green, which I think is the one which Mr. Cruikshank refers to, May 17, 1946, he mentions this pamphlet that has the price as set forth at page 518, and there follows thereafter a statement on pages 518 and 519 of part I of the hearings on S. 1606 in April 1946. I think that is what you are talking about?

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. Is there anything further?

Senator MURRAY. No. If you have any further statement to make, we will be glad to have you do so, in regard to the questions asked you here today.

Senator SMITH. I have especially in mind those things that you put in last year, or were put in last year, to see that they are brought up to date.

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. Any changes that have been made, we would like to have them. I should be personally interested in some evidence of the inability or the unwillingness of hospitals to take care of emergency ambulance cases.

Mr. CRUIKSHANK. Yes, sir.

Senator SMITH. Thank you very much.

Senator DONNELL. Mr. Chairman, I ask that there be incorporated at this point in the record an article from the National Republic of July 1947 entitled "The Case Against Socialized Medicine" by Lawrence Sullivan, and that if possible the pictures that appear therein be reproduced; if that is not possible, that the language under the various pictures be set forth, as to the nature of the picture above.

Senator SMITH. What is the document?

Senator DONNELL. It is from the National Republic of July 1947. That is a trade journal.

Senator MURRAY. What industry does it represent?

Senator DONNELL. I do not know. It is some trade journal.

Senator SMITH. Is there any objection?

Senator MURRAY. Well, it does not say where it is published or what organization sponsors it. It seems to me there should be some way of identifying the author of this and the sponsors of it.

Senator DONNELL. If the Senator objects on that ground, I will withdraw it and we will secure the information that is suggested.

t I will
t going
ing the

Senator
ta as to
upplied.

connec-
ether it

hat has

ord and

piece of
proper

nt made
blished,
ure the
is, and

Senator DONNELL. Mr. Chairman, I have no objection, but does Mr. Carey have an additional statement?

Mr. CAREY. Yes, sir.

Senator DONNELL. Has that been furnished to our committee?

Mr. CAREY. Yes, sir; it has.

Senator DONNELL. I have not seen it.

Mr. CAREY. I am sorry. It was submitted.

Senator SMITH. I have both statements here, one by Jacob S. Potofsky, general president of Amalgamated Clothing Workers of America and member of the executive board of Congress of Industrial Organizations, on behalf of the Congress of Industrial Organizations in support of the National Health Insurance and Public Health Act of 1947, before a subcommittee of the Senate Committee on Labor and Welfare, and so on. That is the statement to which you refer, Mr. Carey, that you would like to have introduced in the record?

Mr. CAREY. Yes, sir.

Senator SMITH. At the close of your own remarks?

Mr. CAREY. Yes, sir.

Senator SMITH. We will be glad to incorporate that in the record.

Now, you are presenting your own statement, testimony of James B. Carey, secretary-treasurer of the CIO?

Mr. CAREY. Yes, sir; that is correct.

Senator DONNELL. May I ask, if the clerk will tell us—I am not making any objection, but I would like to know when Mr. Carey's statement arrived. I had not seen it until this morning.

Mr. CAREY. I am sure it was sent. Has the committee clerk received it?

The CLERK. It came this morning.

Mr. CAREY. It was sent yesterday.

Senator DONNELL. Very well.

Senator SMITH. All right, Mr. Carey, we will be glad to have you.

Mr. CAREY. There are some corrections in this statement and therefore I would like to call attention to them as I go along.

Senator SMITH. The reporter will make the corrections as you call attention to them.

Mr. CAREY. I am appearing here as an administrative officer of the Congress of Industrial Organizations to state the position of our 6,000,000 members and their 18,000,000 dependents with regard to the need for protecting their health and that of all the people.

A great deal of testimony has been offered for and against both of the bills that are pending before your committee. I want to make it perfectly clear at the outset that we are urging endorsement by your committee of Senate bill 1320 identified in its title as the National Health Insurance and Public Health Act of 1947.

This bill was introduced by Senator Murray for himself and likewise for Senators Wagner, Pepper, Chavez, Taylor, and McGrath. We do more than urge the endorsement of the committee for S. 1320 as against S. 545. We oppose this latter bill, which was introduced by Senator Taft for himself and for Senators Smith, Ball, and Donnell, as just another charity relief proposal intended to allay the grievous complaints of the very poor. We do not believe that the needs of the American people, the most self-respecting and self-reliant people on earth, can be met or should be met with charity measures. We believe that the health of the people can best be safeguarded by themselves,

rnment
velfare.
7 would
orderly
to meet
nunity.
; before
l to me

nysteria
Many,
tion by
similar

ction is
cements
uding a

worker
produc-
n union
o urged
at they
endless

which would assure continuity of production. We believe there should be a job for every willing and able worker in this country. We believe that enforced idleness of willing and able workers through limitation of production by industrial management is a national crime.

We are likewise of the firm opinion, and we will assume that the Congress agrees with us, that all willing workers should be able to work; that is, they should be possessed of the good health and well-being that will enable them to perform the jobs assigned to them. Like other groups, we do look at the materialities in a situation, and this is one of them. We even believe that production is important, so long as it is production for the use of all of the people. That is one of our material reasons for supporting Senate bill 1320 and opposing the charity dole proposed in Senate bill 545.

I have brought this material aspect of the public health to the attention of your committee because of the widespread, hysterical interest in production. I do not see how anyone could possibly reconcile a statement made one day that all employed workers must be kept on the job, even if the courts are to be drafted to make them stay on the job, and then announce on the next day that idleness induced by sickness of a worker or some member of his family is not so important after all.

Wholly aside from this purely materialistic view of the national health is the decision that must be made as to what the American people deserve.

I feel I will not be challenged when I state that the results of the democratic process during the 172 years of our national existence stand as indisputable proof that our philosophy of government is in general the most successful yet evolved by man.

But our comparatively high standard of living cannot be attributed solely to the wisdom of the 79 Congresses that preceded this one nor solely to the planning ability of industry management. The accomplishments must be credited to the whole people down to the humblest toiler who dug in the ditch.

And yet, while our system is the best, and I believe it to be the best, our accomplishments are far from perfect. It is the judgment of the CIO, of its 6,000,000 members and their dependents, that the time is now here for them and the rest of the American people to reap some lasting rewards for what they have accomplished. We believe the opportunity to enjoy good health through the prevention of disease and other manifestations of ill health that beset mankind should be one of those rewards. We believe this can be accomplished best through an orderly system of health protection such as that outlined in the National Health Insurance and Public Health Act of 1947.

If health care and disease prevention were not national problems, there would be no need for this subcommittee to meet. Unfortunately, however, the statistics reveal that the American people are far from enjoying a general state of good health. It is true, of course, that our armed forces were in a superb state of health or in such physical condition to attain such a state of health under basic training.

However, we cannot overlook the fact that more than 20,000,000 disabling illnesses, lasting a week or longer, occur in the United States in the course of each year. I cite these figures from Public Affairs

of these
nder the
e armed
ir lowest
e general
common

ferred as
victims
re guess
omics of
Data on

Federal
en meas-
of your
e annual
ings due
rified by
ly 1946.
ubsidize
protect
nas been
ation of

expressing the view of the individual CIO member and his dependents.

The bill which we support would cover the cost of medical care for all employed and self-employed persons and those receiving old-age or survivors benefits. Needy persons who could not be insured by their own earnings for one reason or another could be insured by public agencies, not as charity cases but as Americans who deserve health protection and good health because they are Americans. Payments would be made out of the insurance fund for services by a family physician, a specialist, a hospital, or a laboratory.

Everyone would have free choice to get these services from among all the doctors and hospitals that chose to take part in the program. S. 1320 would contribute to a higher quality of medical service by making aid available for medical research and the further training of doctors, dentists, and other technical health specialists.

One of the outstanding attributes of S. 1320 is that it would impose no compulsion on anybody. Americans do not like compulsion any more than they like charity. The bill would give free rein to the group practice of medicine such as the Mayo Clinic or cooperative organizations for medical care. It would provide funds for the States to help them expand their public-health services and to build more hospitals. Physicians would be free to enter or stay out of the program if they chose. If they decided to participate in the program, they could choose the basis on which they would be remunerated, either by salary, by a fee for service, or on a per capita basis.

The national health insurance and public health bill does not specify how the funds should be raised, but the annual appropriation would equal 3 percent of earnings up to $3,600 per year, presumably to come from social insurance premiums levied one-half on employed persons and one-half on their employers. Additional sums would be appropriated from general revenues to cover specified items of service such as dental care and home nursing. The total could not exceed 3½ percent of earnings in the first 3 years or 4 percent in the second 3 years. At that time Congress could review, revise, and extend the program in the light of the experience gained. The system would be administered by an over-all Federal board, but the direct administration of services and funds would fall mainly upon the States and the local communities. The bill would supplement, not supersede existing voluntary plans now in existence, or that might be set up by groups of citizens in the future. The CIO believes that the enactment of S. 1320 would encourage the growth and extension of voluntary plans, just as the national old-age-benefit system has encouraged the growth and extension of voluntary pension plans throughout American industry.

The National Health Insurance and Public Health Act of 1947 should not be confused in the public mind with the Wagner-Murray-Dingell health bill, on which I testified more than a year ago. I regret, of course, that the Wagner-Murray-Dingell social-security bill was not enacted by the Seventy-ninth Congress, and I likewise regret that its provisions are not receiving the favorable attention of this subcommittee.

S. 1320 is by no means a substitute for the Wagner-Murray-Dingell bill. It does lift out of that bill and lay before the Eightieth Congress that most important phase of social security, and that is the health of the people.

national
n which
a needed
irst step
ance sec-
full em-
d annual
loyment-
serve the

I repeat
to reap
r health.
ne. Our
y inade-
ore fam-
rate con-
ease and

nized to
for our
ped, but
y by the
bill pro-

people. Regardless of our varying religious beliefs or the lack of them, it is an inexorable provision of the natural law that man is a social animal. He was made to live in society and living in society implies working with other members of that society for the common good of all in the respective community. When this principle is disregarded, when men exercise their individualism fully without regard to others or their welfare, when in short, individuals do as they please or band together in little minorities to do as they please, there is a violation of natural law and a moral offense. It is only when the processes of society are carried out in orderly fashion that we have a healthy society. The framework of society, within our continental borders, can be described as the United States Government. Through its processes, all citizens render to one another their common obligations, and most certainly it is a common obligation to serve, protect, and extend the health of the entire community, not on a basis of charity but on a basis of justice, the obligation of one man to another.

In conclusion I point out that this subcommittee can base its favorable endorsement of S. 1320 on any one of the three considerations I have mentioned. It can base its endorsement on support of the Deity of increased production; it can base its endorsement on the reward of their industry to which the American people are entitled; or it can base its endorsement upon the provisions of the natural law. The CIO urges the committee to endorse S. 1320 regardless of its motive for such endorsement.

Senator SMITH. Mr. Carey, I have enjoyed hearing your presentation, although I am bound to feel that you do not quite make a fair comparison between the two bills. However, I will not go into that at the moment.

On the assumption that you favor S. 1320 I want to ask you the question I asked Mr. Cruikshank a little while ago. How long would you estimate it would take to organize in the United States by the building of hospitals, the educating of physicians, and so on, so that it could meet the obligations that it would assume, the Government would assume, by enacting the legislation asking the people to pay for this service which they would be entitled to expect? In other words, what time lag would there be to get the organization all set up so that when we do tax people we can be sure that we can give them what they are paying for?

Mr. CAREY. That would be a difficult question to answer and give a definite time.

Senator SMITH. Would you agree with me that there would be a time lag there, that we would have to do a lot of work setting up medical schools and hospitals?

Mr. CAREY. I think it should be recognized as possible. It should have some beginning, with a broad program set forth so it is understood; and then, as time goes on, as we gain experience, we can perfect the program we have set forth. I do not think of it in terms of setting forth a blueprint in which you can say that the following objectives can be accomplished as of a certain date.

Unfortunately—and that is perhaps one of the reasons that I express my regret that the Murray-Wagner-Dingell social security bill was not enacted last year—we would be a year ahead now, I believe, in carrying out our objectives to see improved service in the medical field for the people of this country.

uandary.
aside as
the bill.
to chal-
develop
he poor
e, we all
veloping
and say,
e get to
n, 'After
at of the

our con-
me than

ifference
u are in
ary posi-
hat there

that we

ram that

could fully subscribe to the statements that I make here. And that is true of every organization dealing in this field that I know of, that is, dealing in the field of representing the thinking and needs of the American working people.

Senator SMITH. Well, you are expressing what we can concede there is a need for—I am not arguing with you on that—and that we would like to see met, and you are saying that it is your opinion that this is the best way to meet the need. That does not prove the case. It does not give me a blueprint to work on as to the kind of legislation we should pass if my Government is going to assume the responsibility of giving this over-all medical coverage.

Mr. CAREY. I was directing my remarks to the fact that you felt the burden of responsibility in imposing taxation on the people in order to carry out the plans covered by S. 1320.

Senator SMITH. That is involved.

Mr. CAREY. I say that that would be, as we understand it, carrying out their wishes. That would be meeting their desires.

Senator SMITH. You would not ask me to do that this year, when you know perfectly well we could not deliver the goods. You would not want us to tax anybody, and then if they wanted medical help say, "Very sorry, but it is going to take 10 years to organize this."

Mr. CAREY. Yes, sir; I would. I would want you to be responsive to the needs of the people and carry out their expressed desires, and that would be immediate favorable recommendation by the subcommittee of the enactment of S. 1320.

Senator SMITH. Without suggesting to us how we can deliver the responsibility we have assumed by that system of taxation?

Mr. CAREY. This would not be the end-all and be-all. We would have to give it consideration, all these questions relating to it, but I am meeting directly your suggestion that we do not have a plan acceptable to the people, in that we do not have a plan.

Senator SMITH. No; I am not saying acceptable to all people. I said a plan that would convince us that it was practical. I am trying to have you tell me how we are going to develop a system of setting up medical schools to fill the lag in the number of medical practitioners, in the number of dentists.

All the evidence shows that we are short of doctors, short of dentists, short of nurses, short of hospitals. We might start now a program by making provision for further education of doctors and dentists and so on, but when you get to the place that you are taxing all your people on the representation that you are going to give medical coverage, I want to go a further step and ask how long it is going to take to do this. That is the first thing here. And when are we going to be able to deliver along the line that we have promised?

You know as well as I that from anybody taxed for this service and who does not get the service, there will be quite a big roar and criticism of the Government. I am trying to get the practical side of it, because we have to develop legislation here if we are going to do something along this line, and our alternative is simply that we make Federal appropriations, grants-in-aid to the States and say, "Go on; experiment with this thing and find out what is the best way to set up a program that will take care of the workers."

I am just as much for the principle as you are, but I think the other approach is better—the trial-and-error method. I think that will get

between
bill and
side and
r side, I
y that I
you are,
to show
able to
in here
nization
to a tax
ckness—

say that
member

this is a
of labor
a great

d under
I can-
ults that

to solve the problem, and I suggested that I could see very readily how the members of your large organization—as you say, 6,000,000 members and 18,000.000 dependents—would, of course, be glad to join the plan—I think they would—whereby, by weekly payment into a fund, they would be assured over-all medical protection. I know I would, if I could do that, because all of us have what is known as catastrophic illnesses—operations, something of that sort. But our problem as legislators, without prejudice, is to try to find out the best way to bring about that result. You have stated that you feel and your group feels that the S. 1320 approach is the correct approach to it and you feel that that would work. I just raise the practical question of the intermediate steps we would have to take in educating the medical profession, in getting more men into the medical profession, more hospitals, more public health centers, and better organizations of our States and counties, getting down to the lowest level, so that everyone would be adequately taken care of.

How long would it take to organize that before we could call upon our people to pay for that service? And I think you are quite correct in answering that you cannot predict how long that will take. It is hard for any of us. But you have stated and other witnesses have stated that you feel the membership of the CIO would be willing to be taxed today and look forward to that in 10 years, or whatever time it might take.

Now, that is the position where I would raise a question as to whether we realize the full significance of that, because I think anybody who begins to pay into this so-called social insurance fund would be entitled to the service from the time he pays in. Those who pay this year should be entitled to something this year. I am troubled by that feature of the program, I admit.

Mr. CAREY. The bill itself does not provide for the services. It provides for the payment of the cost; it provides the kind of organization—and I might say that I speak primarily as an organizer and administrator—and one parallel that we would have is that when we invite workers to join a union, they might be members of that union for some time before they can receive any actual benefits from it in the form of a contract negotiated, providing certain wages, hours, and working conditions in their behalf. And we quite frequently have instances in our society where that takes place. It is not as you purchase a sack of sugar, putting the money down; but the advantage of the proposal now before us is that we will have better health services as a result of this process that is proposed in S. 1320.

Senator SMITH. I might suggest this, that I could see the analogy where you say: "Yes; we will have a plan, and anyone who wants to join the plan, and whoever joins the plan puts money into the pot and gets the benefit of the use of that money for the services."

I agree that that could be turned over to a certain individual, the actual money, and let him go and buy the services; but what gets me rather upset is that the Government is to furnish the services. On the voluntary basis, I have no trouble at all because I myself pay premiums into a hospital fund, and you have probably paid into some sort of a hospital fund, or you have in your union certain welfare funds. But those are on the voluntary basis. This is compulsory. On the voluntary plan a person does not have to join if he does not want to; but this plan suggests that everyone has to join—make it

om pay
iot con-
ne may
ole who
ming it

ing for
ucation

ll plan,
can de-
e, "You
ould be
veloped
vill, but
pointing
e. I am
proach;

hy of S.
on it as
e States

with the splendid groups you represent—and I say that advisedly—you have a splendid organization; I have talked with your leaders, and I have great respect for them; you are doing a wonderful work but you do have a chip on your shoulder, maintaining that everybody is against you who happens to be on the other legislative side, and that is not true—the sooner it will be seen that we are trying to work to our objectives.

Mr. CAREY. We recognize honest differences of opinion, but I think I would have no reason to believe, as a representative of labor, that people are against us, without good and sufficient reason, and the people of labor are against people that are not of labor. It works both ways. I have criticized fellows on the other side just as much as I have criticized my labor friends. I think it is a rather deplorable thing that there should be such prejudice and opposition to this common problem of the American people.

Senator SMITH. Are there any questions?

Senator DONNELL. I would like to ask a few questions.

Mr. Carey, I understood you to refer a little while ago to the desire to secure under S. 1320, health services, and it was the view of your organization that they will be secured. Am I correctly interpreting your statement?

Mr. CAREY. Yes.

Senator DONNELL. I wonder if you have examined some of the details of S. 1320, with a view of determining just what the quality of service is that is provided by that bill and is guaranteed by the bill.

Have you studied it with that in mind?

Mr. CAREY. Not with that in mind. The bill itself provides the services and provides payment for the services. I would think that under S. 1320 we would have better health standards in the United States. I say that after the consideration our organization has given to all the principles involved here. I do think that through this orderly process that would be contained in the provisions of Senate bill 1320, we would be breaking new ground and we would be doing it in a way that is consistent with the traditions of our country. It would improve our opportunities in the future, even to the extent of improving the opportunities to break ground in the medical field itself, where we have had tremendous progress, but we have not been able to translate the progress that was made in the development methods in the medical field to all the people, and S. 1320 would enlarge our opportunities to have the people, all the people, receive the benefits of the progress made in this important field.

Senator DONNELL. Mr. Carey, I appreciate your desire for better health services. We all concur in this, and I readily understand, in reading the declaration of purpose as set forth in S. 1320, that it specifies very laudable ultimate purposes. The development of adequate health services stated in this preamble—

> is essential to maintain and improve the efficiency, security, and well-being of the American people.

Then it is provided further on, on pages 4 and 5, that the Congress finds and declares that—

> to promote the general welfare of the people of the United States, the Congress hereby establishes a national health program—

electing

in this
to pro-
ards of
of pro-
andards

at any
o objec-
n select-
nd that
nt with

on here
hoice in
cord, or
make it
fluenced

and their reasons for disappointment should this bill be enacted and it does not live up to its purposes.

I find nothing in the bill that would indicate that it would not. In fact, I have reason to believe that there is a great deal in the bill that does offer a promise of improvement in this field. I am quite certain, speaking again not as a doctor, but an organizer and administrator, that this bill as set forth is a glorious opportunity for the American people to have for the first time the benefits of the progress made in the field of medicine.

Senator DONNELL. That is one of the prime reasons for your support of the bill, that you sincerely believe that the bill will produce that?

Mr. CAREY. That is correct.

Senator DONNELL. And if the bill does not produce it, you are going to be greatly disappointed?

Mr. CAREY. Correct.

Senator DONNELL. On this matter of free choice of physicians, are you familiar with the fact that the bill permits, and in fact expects that doctors will have the right in the respective communities of the country to elect whether they will adopt a per capita basis of payment, with practitioner lists giving the numbers of persons, I take it, who will be on the list of the specific doctors. Are you familiar with that?

Mr. CAREY. Yes; it goes beyond that. It provides that if the majority of the doctors in an area decide on one basis and some do not care to go along, they do not have to become part of the program, or they can work out some other satisfactory arrangement. I think the bill has been very considerate, not only of the need of the patients or potential patients, but also of the medical profession.

Senator DONNELL. The bill, I take it, would not obligate any doctor to accept its terms or to adopt one of these practitioner lists?

Mr. CAREY. That is correct.

Senator DONNELL. And of course, if the doctor did not come under the bill, did not voluntarily avail himself of the right to come under the bill, there would be no way that you and I have, as taxpayers, to require him to give us his services under this bill. That is correct, is it not?

Mr. CAREY. There is no obligation on the part of the doctor except a moral obligation, the oath he takes in becoming a doctor, and the fact that the conditions are made extremely attractive for him, but still his right to strike—and there have been cases of that kind by professions—the right of opposition, the right to campaign against the proposals here are all fully adequately protected and I would say that the medical profession itself can continue—and I emphasize "continue," to prevent the people from having their opportunity of their wishes being met under the system that is contained in S. 1320.

Senator DONNELL. You refer to the oath of a doctor. Is there any oath that a doctor takes to go into this system under S. 1320?

Mr. CAREY. I think there is an oath that a doctor takes to do the best possible job he can do in behalf of the health of the people, and I think that oath carries with it the expectation that he will look objectively at S. 1320, and one reason why I say eventually the greatest champions of this proposal contained in S. 1320 will be the medical profession of this country.

you not,
80 to 90
d to this

I believe
e was at

am sure
ed to it.
sk you a

ust been

to bring
e of this
d for it.
ter how
e in this
t. They
tary in-

e found
prepare

ductive ability on the part of the people. We have superior developed resources. There is no reason under the sun to stop just there. We have a path to follow, as I see it, and as we consider these matters we might also say that one reason for the reduced objections to the program contained in S. 1320 is the fact that there is more information now.

Since I have been testifying, for instance, the word "socialism" or "communism" has not been mentioned.

I think we can get down to the meat of the question and that is why I say it is well that we consider the need and consider the bill as to whether or not it is a framework and a mechanism in which the need can be met. I would say "Yes."

Senator DONNELL. Mr. Chairman, I wonder if the Senator would mind if I continued my examination. This sort of gets me off the track.

Senator MURRAY. I take up very little time in cross-examination, Senator. The Senator will find, as we analyze this record, when it is concluded, that my contribution in the form of questions or statements is very insignificant compared to the statements which have been incorporated in the record by others. I do not want you to feel that I am imposing on the committee the few times that I interpose any remarks.

Senator DONNELL. Mr. Chairman, I have no objection to the asking of any and all questions that the Senator very properly has a right to do. I am sure, though, that the Senator will not object to my having continuity in my examination.

Senator MURRAY. That is the reason I interposed there before you started, because I did not want to interrupt you after you had started the trend of questioning.

Senator DONNELL. I had been on the trend, attempting to get down to a further question. I would really like to proceed with the examination, if I may.

Senator SMITH. Proceed, Senator.

Senator DONNELL. Now, Mr. Carey, I had asked you some little time ago about whether you have examined the provisions of this bill to see what guaranty there is as to the quality of service that the bill does provide. You have examined the declaration of policy and the laudable purposes and the very high and noble objectives that are sought.

I am asking you whether you have examined the bill to see whether there is any guaranty of those things being carried out. Have you done that?

Mr. CAREY. Yes.

Senator DONNELL. I will ask you then as an illustration, what type of hospital service is guaranteed by the bill, if you recall?

Mr. CAREY. I think that as a result of the enactment of this bill and the application of this principle, we will have hospital provisions far superior to those in existence now.

Senator DONNELL. I will ask you what provision in the bill that is? Perhaps I did not state it as concretely as I should.

What provision in the bill is there that guarantees any particular type of hospital treatment or care or service? Do you have in mind the guaranty in this bill that a better service along hospital lines is to that

w of—
chnical
would
ly pro-
S. 545
ogram.
ey, the
ne con-
d says,

-bed ac-
akes the
n agree-
hospital
ts from
occupied
benefits

follow-

y comultimate objectives, the hospital has the right to, distinctly reserved to it in the bill, require that the patient shall pay for the additional facilities over and above what the bill guarantees.

Senator MURRAY. May I interpose a question right there? Under existing conditions, many people in this country find it impossible even to get into a hospital where they could use those multiple-bed accommodations. In fact, they do not get in at all, and this bill certainly will make it possible for the people of the country to get hospitalization even though they occupy the less expensive bed.

Senator DONNELL. May I ask the Senator, Does this bill, S. 1320, provide for the construction of hospitals? We have the Ball-Burton bill for that purpose, and this bill, S. 1320, has nothing to do with the construction of hospitals?

Senator MURRAY. No; but it has to do with the support of the hospitals after they are constructed.

Senator DONNELL. But it contains the provisions I have read, does it not, Senator, with respect to the hospital facilities that are guaranteed in the bill?

Senator MURRAY. Oh, yes.

Senator DONNELL. Now, I would like to call attention further—I do not think this is ultratechnical—you have come here to give us your opinions about this bill and you have studied the bill, have you not? Have you read the bill from cover to cover?

Mr. CAREY. Yes, sir.

Senator DONNELL. If you do not mind turning to page 8, line 20 says this:

> If the Board after consultation with the Advisory Council finds that the personnel or facilities or funds that are or can be made available are inadequate to insure the provision of all services included as dental, home-nursing, or auxiliary services under section 201 of this title, it may by regulation limit for a specified period the services which may be provided as limited or modify the extent to which, or the circumstances under which, they will be provided to eligible individuals. Any such restriction or limitation shall be reduced or withdrawn as rapidly as may be practicable and, in the case of dental services, priority in the reduction of withdrawal of any such restriction or limitation shall be given to children.

So we find, do we not, Mr. Carey, that you are not going to get just 100 percent under this bill, all kinds of medical services, hospital, home-nursing, auxiliary, and dental services, but the Board, if it finds there is not enough money in the sack, has the right to restrict and by regulation limit for a specified period—and I am quoting—"the services which may be provided as benefits" to be eligible. That is provided in the bill, is it not?

Mr. CAREY. I think that is a very fair statement. It does not hold forth any promises that cannot be accomplished. It tells the people just exactly what they can expect. It does not promise perfection or Utopia. It tells them that there might be shortcomings. It tells them that in the event shortcomings exist, fair steps will be taken in order to establish some system of priority that will give greater consideration to children. I think it is a splendid provision. I am pleased that those who prepared the legislation incorporated that in the bill. It is the kind of provision that all people can readily understand.

Senator DONNELL. It is not overtechnical, is it?

estions

under-

s clear

e bill?

s, Mr.

plane

other

uch as

nd we

y. We

sk you

ow the

sion of

And I have also talked with other people in the same capacity in other countries including the Soviet Union.

Senator DONNELL. How about New Zealand? Did you talk to anyone in that country?

Mr. CAREY. I have some of them, but not as much as I have in some of these European countries, and not nearly as recently.

(Subsequently Mr. Carey addressed the clerk of the committee as follows:)

CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington 6, D. C., September 3, 1947.

Mr. PHILIP R. RODGERS,
Committee Clerk, Labor and Public Welfare Committee,
United States Senate, Washington, D. C.

DEAR MR. RODGERS: I wish to acknowledge receipt of your recent letter requesting the names of the foreign officials with whom I discussed the effects of compulsory insurance upon the standards of medical care.

I am attaching a list of names so that you may include it in the official publication of the hearings. Most of these people participated in the several discussions in varying degrees.

Sincerely yours,

JAMES B. CAREY, *Secretary-Treasurer.*

Union of Soviet Socialist Republics.—M. P. Tarasov, Mme. N. V. Popova.
Great Britain.—V. Tewson, A. Deakin.
France.—B. Frachon, L. Jouhaux, G. Monmousseau.
Mexico.—V. Lombardo Toledano.
China.—H. F. Chu.
Australia.—E. Monk, E. Thornton.
India and Ceylon.—S. A. Dange, V. B. Karnik.
Belgium.—E. Kupers.
Italy.—G. DiVittorio.
Czechoslovakia.—A. Zapotocky.
Africa.—B. Goodwin.

Senator DONNELL. Do you like the Soviet plan, concerning which you have had discussion with people from Russia?

Mr. CAREY. I would not use that model. I prefer to keep on S. 1320, if I may.

Senator DONNELL. Have you read any official reports or articles, by commentators, of any nature in regard to the success or failure, or intermediate ground between success and failure, of Great Britain's experience, particularly as it reflects itself in the quality of medical service that has occurred?

Have you read any such reports or comments?

Mr. CAREY. Yes; I have. And I might say at this moment that I am here to testify on behalf of a great number of other people. I cannot detail the kind of reading they have engaged in in this field, but they express pretty firm opinions with regard to many of these questions, and when Senator Murray and I raised the question about the kind of opposition that the principles contained in S. 1320 received, I did admit that a lot of argument was developed on the basis that in this country we have superior medical services rendered the people, and that I readily grant, but as to saying that we cannot improve our medical services, I would say there is a great deal of room for improvement, based on my personal experience, what I have read and what others have had in terms of experience, and in terms of the needs of the people I represent.

Senator DONNELL. I am wondering, Mr. Carey, if you can tell us of any specific article, booklet, pamphlet, document, that you have quality

I mean
or un-
ng that
rvice of
existing

names

f them?

ou say,
that, I
is that
to state
mplates
hat tax

e is re-
of this

s a per-compulsion on anyone, I am sure we could save a considerable amount of time.

Senator Donnell. I have always understood that the assessment of taxes involves an element of compulsion and I still think so, notwithstanding your argument that this bill is free from compulsion.

Mr. Carey. By "compulsion," I mean no compulsion other than that which a citizen is obliged to do, to maintain citizenship and good standing in a community. There are certain things that a citizen is required to do, it is true, and I say there is nothing in this bill where the people are compelled to do things against their will, for their benefit.

Senator Donnell. Even after we have paid the taxes, then, this bill does not compel us to accept any benefits under it? That is what you mean?

Mr. Carey. That is correct. And there is compulsion in this sense that a person, even though he has no children, is compelled to pay taxes to support these schools. I think they get benefit from that. There have been people, citizens, that pay their taxes and send their children to private schools. They are compelled to support the instrumentalities of society for the education of the children generally. So, in that sense it might be considered that there is compulsion. Certainly there is.

Senator Donnell. You referred earlier, Mr. Carey, this morning to the fact that you and the A. F. of L. representatives, and possibly you mentioned someone else, would all agree, generally speaking, and you referred a while ago that there had been no collaboration in the preparation of the material that has been presented here to the committee; that you could all agree on the principles that you have presented here?

Mr. Carey. Yes, sir; I stated that after listening to the representative of the American Federation of Labor, Mr. Cruikshank, and I am quite certain if you put, not the words, or the thought contained in it, but the principles in the testimony he presented and the testimony that I, as a representative of the CIO present here, you will find they are very consistent; or if you take the statement that was presented for the record by Mr. Potofsky, you will find that they are consistent with these.

Senator Donnell. In fact there is a very striking similarily, is there not, Mr. Carey, in a great many of the statements that have been presented to this committee? They take up, for instance, the American Medical Association's finding and with respect to medical indigents; they refer to the "charity" nature of the Taft bill; they go into the numerous questions in which there is a very striking similarity in the statement, is there not? There is no question about that?

Mr. Carey. There is no question but that there is a striking similarity in the positions they take; yes, sir. I might say, Senator, that that is not surprising because this is a matter that has been thoroughly discussed. I do not think there was any collaboration between the members of the Resolutions Committee of the A. F. of L. in their meetings or the meetings of the CIO Resolutions Committee in their meetings, and yet their resolution adopted on the subject contains the same general ideas, and especially on this question with regard to whether we should take the principles contained in S. 545 or the approach contained in S. 1320, and I think that in each instance, and

irecting
ition on
y other
ent that

any of
previous

familiar
held on
tion has
Admin-
led over
n repre-
ou not?

, who, I

hearings

Senator DONNELL. I think so. You do not regard taxation laws as a matter of contribution, do you?

Mr. CAREY. It is contributions but some people can do it voluntarily, but those that do not care to do it in a voluntary manner ought to be required to do it.

Senator DONNELL. But at any rate, taxation as imposed by law?

Mr. CAREY. That is correct, sir.

Senator DONNELL. At this meeting held, over which Mr. Falk presided, and in which he made these observations—others that I shall not take the time to read—there was present Henry Bookbinder, assistant director of research, Amalgamated Clothing Workers, CIO, is he not?

Mr. CAREY. I believe he is; I am not certain.

Senator DONNELL. Well, you know Mr. Bookbinder, do you not?

Mr. CAREY. Not too well. The Amalgamated Clothing Workers are part of the CIO.

Senator DONNELL. I will ask you—do you know whether Miss Elickson was there?

Mr. CAREY. I suppose she was there. If she was not, she should have been. I will say that.

Senator DONNELL. I have a number of other persons that are listed as having been there: Miss Diana Farnham, United Office and Professional Workers of America; Mr. William Glasser, International Longshoremen and Warehousemen's Union, CIO; Mr. Godwin, United Automobile Workers, CIO; Mr. Clayton E. Johnson, director of unemployment compensation department, United Automobile Workers, CIO; Miss Eleanor Kahn, research analyst; L. E. Caslo, research director, Rubber, Linoleum, and Plastic Workers, CIO; Miss Ailene Link, research associates, American Federation of Hosiery Workers, CIO; Miss Esther Peterson, whom I know and who was here in the room, and now is legislative representative of the Amalgamated Clothing Workers, CIO; Mr. R. Shulman, research director, Marine Shipbuilding Workers, CIO; Miss Jean Weinstein, director, American Newspaper Guild, CIO; Mabel M. Weir, research director, Oil Workers International Union; A. L. Wuidaman, office of the president, United Automobile Workers, CIO.

Those are all listed as having been present at that meeting, and I assume the listing is correct.

Senator MURRAY. Miss Peterson is not in the room now.

Senator DONNELL. She was. I saw her a while ago. We will have the record clear. No objection to that.

Now, Mr. Carey, just one further question: Have you made any examination as to what expenses will be incurred after the year 1955 under S. 1320?

Mr. CAREY. No, sir.

Senator DONNELL. You referred to certain limitations in the bill in the early years of its operation. You have not made any study of it, have you?

Mr. CAREY. I said after a period of time. I think I specified about 6 years, Congress—and I say "Congress"—can give consideration to extending and taking care of other—taking other steps to extend the services to be rendered to the people of this country in the light of their experience. I am not using exact words, but the general notion. But, frankly, I would think that was a little too far to look forward to at this time, because the bill has not yet been enacted.

you are
all as to
years of

nis time,

keeping

nt and I
are not
xpressed
have an

have ex-

the peo-
subject?

out, now

Senator Donnell. Has there been a poll taken of those members?

Mr. Carey. Yes, sir.

Senator Donnell. When was that poll taken?

Mr. Carey. The poll was conducted in the orderly processes of our organization. I mention in my testimony, in the national convention of the CIO, and the national convention of the affiliated organizations and the State organizations and in the committee organizations and in the local union bodies and in the district council; I am trying to anticipate your question as to whether or not we sent out post cards. My answer is "No."

Senator Donnell. In other words, there has been no poll of each of the individual 6,338,000 members of your union as to their opinion on S. 1320? That is correct, is it not?

Mr. Carey. In our processes we consider that is the way of telling their opinion, by having it from the local union.

Senator Donnell. I might just ask you again: Has there been anything sent directly to each of the 6,338,000 people?

Mr. Carey. No, sir.

Senator Donnell. That is all.

Senator Smith. I might remind the subcommittee that this witness would like to get a certain plane, at what time?

Mr. Carey. At 1:40.

Senator Murray. I would like to ask just a few questions.

Mr. Carey. I will be delighted to return at some other time, at the need of the committee.

Senator Murray. We appreciate that but I hope it will not be necessary to bring you back here again.

ou feel that if this bill is put into operation there will be eventually a great improvement in the health of the American people?

Mr. Carey. Yes, sir.

Senator Murray. And that, in turn, would tend to decrease the cost of the operation of the plan?

Mr. Carey. Yes, sir.

Senator Murray. It would result also in a great increase in the members of the medical profession?

Mr. Carey. It would result in an increase.

Senator Murray. And in nurses. So that, as a result of the combined operation of the bill, the health of the Nation would be greatly advanced, and thereby the cost of the complete operation of the bill would be greatly reduced?

Mr. Carey. May I add on the other side, there would be a tremendous saving in what can now be considered a wasteful method of operation, measured in terms of loss of production by illness and other things.

Senator Murray. I put into the record here, the other day, statistics showing the great losses that this country suffers as a result of ill health. Industry, for instance, annually loses many millions of dollars as the result of ill health of its workers. Improvement in that connection would be a great advantage to business and industry in this country?

Mr. Carey. Yes; it would.

Senator Murray. There being great need for a program of this kind, you feel that the working out of the provisions of the bill is

here to
rence to
om way
e failure
country.
You do
lueprint
done by
It is the
the pur-

But we
we had
now this
be stag-
s opera-
me here
ers, and
ion that
in this

I have
Senator

country as a whole, to meet the entire problem in this country, we then would have a system of really socialized medicine, would we not?

Senator Donnell. You are not in favor of socialized medicine, I take it, Senator?

Senator Murray. I do not care what kind of medicine you call it. We should have medical care for all.

Mr. Carey. I am going to answer that by stating I would not know.

Senator Murray. You would not know what the effect of that bill would be?

Well, anyway, you think that S. 1320 more adequately meets the needs of the country than S. 545?

Mr. Carey. Yes, sir. That is why we are so wholeheartedly in support of S. 1320.

Senator Pepper. I am aware of your time limitation, Mr. Carey, and I am just going to ask you this: As I see it, the core of S. 1320 is simply to provide a method by which the masses of the people of this country can pay for the medical care that they need. Now, the doctors, except in the sense that they also are taxpayers are not going to be the great payers of these fees that this law will require, because there are only a couple of hundred thousand doctors in the country, but what impresses me is that Mr. Cruikshank came here, appearing for 7½ million members of the A. F. of L., of the working people of this country, and you come here appearing for over 6,000,000 working people of this country. They are the ones that will be getting wages on the pay rolls of the country. They are the ones who will have to pay the tax, and you come here to say that "we, who are the ones that will bear the burden of the tax, want to pay the tax because it is the way we can budget our medical care," and you say that "the doctors, who will get the money that we pay in, have no right to block us before the American Congress from the the right to pay the taxes that will give us a way to meet the budget to pay the medical needs of the family."

Is that not about the gist of it?

Mr. Carey. That is correct. I do not say that that is the position that will always be held by the doctors, the position of opposition. I would say that that is changing. Certainly it is not changing rapidly enough to cause the medical profession today to understand the provisions of Senate bill 1320 sufficiently to be here testifying as the champions in support of it. I do not look upon it as anything in the form of WPA for the medical profession, but I think there is a moral obligation on their part to support this bill.

Senator Pepper. One other thing. Not only is it true that you are going to have to pay your part of the tax as workers, but it contemplates a tax on the employer, which will add to the cost of the goods, and the workers will have to pay or bear their share of that, too. So that the principal burden of these taxes that S. 1320 contemplates will be on the working people of the country, yet you are the ones who are here asking that you be permitted to pay those taxes.

Mr. Carey. That is correct.

Senator Donnell. The Senator does not at all contend that the pay-roll taxes will pay the whole expense of it?

Senator Murray. Every technician who has appeared here has certainly indicated that it would pay the majority of it.

nd that

have to
priation
gress, as
rt more

Federal

ment of
.

y much

l be in-

llowing
ternoon.

LGAMATED
D OF THE
OF INDUS-
NCE AND

our productive capacity. At least half of the 7,000,000 disabled on an average day are in the labor force and would ordinarily be employed or looking for work. Illness or accident was responsible for the loss of 500,000,000 workdays or about 3 or 4 billion dollars in wages during 1942, when our need for war production was critical.

The simple truth is that our country's health facilities are insufficient and that those most in need of medical care are least able to afford it. Compared with other countries, our medical standards are high. But those health and medical resources which we have are so unevenly distributed that the areas and groups in greatest need have the least service. In spite of the tremendous strides made recently by our public health and maternal and child care programs, there are still 40,000,000 Americans living in communities without full time, local public health services. When one realizes that it would take more than 100 years to cover the whole Nation with public-health services on the present basis, the hopelessness of attempting to provide satisfactory health services without a comprehensive national health program becomes brutally clear.

Present insufficiencies of service are at least equalled by the financial inability of those families most urgently needing medical care. Illness most often strikes those least able to afford it. The medical histories of low-income families are records of premature death and longer and more frequent illness. Yet, although low-income families have greater medical needs than those with higher incomes, they actually receive far less medical attention.

Facts on our insufficient, badly distributed, and poorly organized health facilities and on the inability of large sections of the American people to pay for even a minimum of medical care have been testified to in detail by medical and public-health experts. I shall not linger over them. We believe that the National Government should act to improve the situation just as it has moved ahead to help build roads, improve forestry practices, help the farmers raise healthy animals, and in many other ways develop the Nation's resources. Surely, our people are our greatest resource.

Before the war, about $4,000,000,000 a year was spent for medical care. Three-fourths of this was spent by patients and their families; one-fifth by Federal, State, and local governments; and the rest by industry and philanthropy. The costs of medical care can be fairly well predicted for large groups, and the distribution of risks and costs can, therefore, be spread to provide medical care for those least able to pay for it themselves. There is nothing new about this idea. Our educational system is based on the same principle.

To a certain extent, various insurance plans have been attempting to do this for years. The insurance program of the Amalgamated Clothing Workers of America had its origin in the establishment of an unemployment insurance fund in Chicago in 1923. After the enactment of the Social Security Act in 1935, it was converted, by agreement with the employers, into a life and health insurance plan which went into effect in 1940. The Amalgamated, which had pioneered in the field of unemployment compensation, then embarked on a program to protect its members against the financial burdens of death and disability. At the present time, almost 300,000 of the 325,000 members of the Amalgamated are entitled to benefits. These include death, accident, illness, maternity, and hospitalization benefits. And—parenthetically—I should like to remark that men's clothing workers receive, in addition, retirement benefits. That this insurance is answering a long-needed want on the part of our own members is best shown by the fact that up to March 1946, in almost half the deaths, the Amalgamated policy was the only insurance left by the member.

But, industry-supported plans cover relatively few workers. More extensive in coverage, although still not meeting actual needs, are the voluntary insurance plans, such as the Blue Cross plans. These now cover about 13,000,000 people—less than one-tenth of the entire population. But, although the success of these plans demonstrates the possibility of insuring middle-income families against hospital expenses, their costs are so high that they cannot be extended to the low-income families most in need. And, although these plans help make existing facilities available to those who can meet the costs, they do not touch upon the vital fields of medical care other than hospital care. Even our own Amalgamated insurance program does not provide medical service as such, but helps defray the expenses of such care, and then only partially.

The essentials of a good national health program are simple to formulate. The cardinal purpose of such a program is, above all, to place satisfactory medical and hospital care within the reach of all the people. More hospitals and more doctors must be available to those groups and in those areas of the country

rnal and
panded to
l medical
y painful

for a na-
le on too
intended
a method
nat small
dical and
) are not
funds au-
isions for
the most,
Further-
ovide for
, in fact,
ealth and
It sets
voluntary
vision for
ple, taken
y admin-

er, would
complete,
care and
ysician of
ays a firm

Senator SMITH. Before you begin your testimoney, Mr. Hansen, I want to read for the record, because I want to stress these points—I will postpone that for a moment.

Mr. Hansen, we will be very glad to hear you. Will you tell us just who you are, what is your job, and how you qualify as a witness here?

STATEMENT OF HORACE R. HANSEN, GENERAL COUNSEL, COOPERATIVE HEALTH FEDERATION OF AMERICA, ST. PAUL, MINN.

Mr. HANSEN. Mr. Chairman and gentlemen, my name is Horace R. Hansen. I am a practicing attorney in St. Paul, Minn. I am counsel for the Cooperative Health Federation of America, and appear here by their specific request.

Senator SMITH. That is not the same organization that is the Committee for the Nation's Health?

Mr. HANSEN. No; it is not. We are not affiliated with the Committee for the Nation's Health.

Senator SMITH. Could you give us a little statement of what the Cooperative Health Federation of America is?

Mr. HANSEN. Yes; I intend to do that in my statement.

Senator SMITH. Then proceed in your own way, Mr. Hansen. We will be very glad to hear you.

Mr. HANSEN. I am also here to represent the Cooperative League of the United States.

Senator SMITH. Does that mean the so-called cooperative movement in the United States?

Mr. HANSEN. Yes, sir.

Senator SMITH. Farmers' cooperatives and any other cooperatives?

Mr. HANSEN. All of the cooperatives who are affiliated with the Cooperative League of the United States and by their specific authority in the resolution passed unanimously in the cooperative held at Columbus, Ohio, in September of 1946, and by recent action of their board of directors I appear here and testify.

Senator DONNELL. That is action taken by the Cooperative League?

Mr. HANSEN. The Cooperative League of the United States with headquarters at 343 South Dearborn Avenue, Chicago.

Senator SMITH. You are not counsel for that league? You are just representing them for this purpose?

Mr. HANSEN. I am representing them for this purpose. That is correct.

Senator SMITH. Are you a member of that Cooperative League?

Mr. HANSEN. The Cooperative Health Federation of America is an affiliate of the Cooperative League of the United States.

Senator SMITH. What is the over-all membership of the Cooperative League, which I take it is a parent body—what is the membership of that?

Mr. HANSEN. The membership roughly is 2½ million American families, approximately 10,000,000 people.

Senator SMITH. The Cooperative Health Federation—how large an organization is that?

Mr. HANSEN. That has about 150,000 memberships.

Senator SMITH. Is that a branch of the Cooperative League you are interested in as general counsel?

y inter-
he view-

tee, and
, official
Federa-
igh our

ion that
at Two

h work-

lems.
, one of

is what

specific
I would
for the
ntaining

(*d*) That programs of preventive medicine and public health, including services for mothers and children, will be broadly conceived and administered;

(*e*) That Government will share responsibility for a more favorable distribution of medical personnel and facilities;

(*f*) That provision be made in legislation that will assure to all the right to free choice of physician and freedom to designate the plan with which they wish to be associated;

(*g*) That Federal, regional, State, and local administrative and policy-making councils, boards, or committees provide for a majority or equal representation from organized consumer groups;

(*h*) That there be a maximum decentralization of administration and local control.

3. That in all legislation in the health and medical-care field the interests of consumers be protected through consumer representation on policy-making councils, boards, or committees;

4. That legislation be sought, through new bills or through amendments to existing legislation, for grants and/or loans to consumer-sponsored organizations for capital expenditures or purposes of establishing new facilities or expanding and enlarging existing facilities including health centers and hospitals;

5. That the new national organization of voluntary plans be instructed to further the above policies by public education and other appropriate means; and be it further

Resolved, That any association or federation which is organized at this conference be requested to set up, and provide a budget for, a committee of well-qualified persons whose duties it shall be to:

1. Study ways and means of carrying out these principles;
2. Cooperate with other groups in efforts to achieve those aims;
3. Analyze any proposed legislation relating to the achievement of these aims;
4. Make recommendations to the members of such association or federation with regard to action on any such proposed legislation; and
5. Carry out any other related activities as may be determined by the board or the membership.

SPECIFIC PROVISIONS THAT MUST BE INCORPORATED IN NATIONAL HEALTH LEGISLATION IF SUPPORTED BY CONSUMER-SPONSORED VOLUNTARY-PREPAYMENT ORGANIZATIONS * * *

National health legislation, to receive the support of the Cooperative Health Federation of America, must contain assurances that when voluntary organizations are operating in the public interest and are providing services to consumers of medical care, such organizations will not be discriminated against. Now existing voluntary-prepayment plans want, also, assurance that they will be free to compete, on an equal basis, with each other and with other types of organizations for medical services or with physicians practicing individually. Organizations established for the purpose of providing a medical service to their members must be free to expand their programs and membership and not be forced to change the basic character of their plan for medical services because of the existence of a national-health program. There must not be anything in the law that will prohibit or unnecessarily impede the establishment of new voluntary medical-service organizations.

To assure these objectives the following circumstances must be provided for in Federal legislation receiving the unqualified support of consumer-sponsored health-medical-care plans:

1. That any national-health program intended to improve the health status of the American people through removing existing economic barriers to necessary care and through making professional personnel and health facilities uniformly available throughout the country shall be based on the principle of medical service benefits to the individual and not cash benefits, providing, however, that disability insurance for income maintenance should be paid in cash benefits.

2. That organizations providing a medical service may negotiate contracts with Government to provide services to beneficiaries who select the particular plan by free-will designation, the terms of such contracts to be not less favorable than those contracts negotiated by Government with other organizations or individual providers of services for the same type of benefits.

3. That Government will be prohibited from granting exclusive rights to any corporation or organization of consumers or providers, or a combination of con-

roviders,
s of con-
rogram.
entering
type of
r regula-
resenting
ent, and
class of
apply to

any pro-
medical
n is ex-
his pro-
contract

associa-
them in
) to act
oney for
with any
ation by
esignated

y agency
(*a*) Dis-
services
amount

THE COOPERATIVE LEAGUE OF THE UNITED STATES OF AMERICA,
NATIONAL FEDERATION OF CONSUMER COOPERATIVES,
Chicago 4, Ill., July 1, 1947.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: The Cooperative League of the United States appreciates very much this opportunity to present before this committee testimony regarding the health problems of the American people. The cooperative league includes in its membership some 2½ million American families from all walks of life joined together by their mutual belief in the benefits to themselves and their country which flow from the application of cooperative methods and principles to the people's problems.

The cooperative league includes as one of its affiliates the Cooperative Health Federation of America, along with other cooperators operating in other fields of social and economic activity. It is logical, therefore, that testimony on health legislation should be presented for both the Cooperative League and the Cooperative Health Federation by the person designated by the board of directors of the Cooperative Health Federation. I regret that it is impossible for me to be present personally to introduce Mr. Horace Hansen to the committee, since he has been so designated.

Mr. Hansen will speak to the committee for the cooperative league generally and for the Cooperative Health Federation of America specifically. In connection with problems involving improvement of health services, enabling people to pay for the preventive and curative services they need, and presenting the viewpoint of the people as consumers of health services, the cooperative league logically takes the position that the health federation should make the specific decisions and determine and set forth the policy of the cooperative movement as a whole.

H. JERRY VOORHIS,
Executive Secretary, Cooperative League, United States of America, and Cooperative Health Federation of America.

RESOLUTION UNANIMOUSLY ADOPTED BY FIFTEENTH BIENNIAL CONGRESS, COOPERATIVE LEAGUE OF THE UNITED STATES OF AMERICA, COLUMBUS, OHIO, SEPTEMBER 9–11, 1946

Millions of people still suffer needlessly from inadequate distribution of medical care in spite of the outstanding progress of medical science.

This Congress commends the medical professions for their signal contributions to the scientific developments which now make possible the wider and more effective distribution of medical care.

This congress commends the medical cooperatives and group health associations for their pioneering efforts in enabling consumers to obtain fuller use of medical services through various types of prepayment plans. It further commends them for their recent action in organizing the Cooperative Health Federation of America.

The Cooperative League has consistently supported and encouraged the development of such voluntary health plans. It gave encouragement and assistance to the meeting which resulted in the incorporation of the Cooperative Health Federation of America. It now urges all cooperatives affiliated with the league to sponsor the establishment of organizations through which the people in their respective areas can obtain medical, hospital, and other health services on a cooperative prepayment basis. It further urges that such organizations will affiliate with the Cooperative Health Federation of America and assist in the distribution of health and medical care on a cooperative basis.

This congress recognizes that efforts of the cooperative movement alone cannot insure in the near future the distribution of adequate health care to all of the people in the United States. For this reason it approves the principle of public responsibility for assuring the availability of health and medical services for all the people without economic or other barriers. To this end it supports:

1. The making of larger grants by the Federal Government to the States for public-health purposes.

2. Nation-wide health insurance under public auspices provided that any proposed Government action in this field—

(*a*) Provided for the continued expansion of volunteer cooperative health and medical care plans on a basis that will permit consumer control of administrative and organizational policies.

admin-

ospitals,

program
ment of

' view-
s com-
to the
ne, how

erested
ntirely
wish to

ayment
oblems;
nedical-
confer-
ist; out
merica
confer-
elected

(*a*) The furnishing, providing, securing, or arranging for medical or hospital services, or services allied thereto, on a prepayment basis, and the maintaining of satisfactory quality in such services.

(*b*) Effective control by users of the services in matters pertaining to policy;

(*c*) Operation on a cooperative or nonprofit basis;

(*d*) Ownership, leasehold, or management of the facilities resident in the users of the services, unless such ownership, leasehold, or management by others does not mitigate control by users of the services in matters pertaining to policy; and

(*e*) Such other qualifications as may be prescribed in the bylaws.

The Cooperative Health Federation of America now represents the majority of the consumers of medical services in the United States who have organized themselves through community, voluntary prepayment medical-care plans for the purpose of removing economic barriers to necessary medical care that exist today for the overwhelming majority of American people.

Not only are these consumer groups organized for the purpose of removing the economic barriers to necessary medical care but they are also organized to establish medical-care facilities for group medical practice.

We believe that it is only through group medical practice that the best interests of the public can be protected.

The federation believes from its own experience—that is to say, the experience of its member associations, some of which have been in existence for as long as 20 years—that health and medical-care services are not generally available for the majority of American people on a basis that they can afford, at standards of care, made available at the teaching hospitals and other hospitals of organized group medical practice, and benefit fully only an exceedingly small fraction of our total population.

Expert medical testimony presented to this subcommittee substantiates that position. We believe that it is only through mobilization of consumer effort and utilization of all the instruments of our Government, Federal, State, and local, that modern medicine can be brought within the reach of all the people.

We would like also to insert as part of the record for the subcommittee's reference our letter to the editor of the Journal of American Medical Association, which was published in that journal in the November 1946 issue. We have marked that as our "Exhibit 4."

(The letter referred to, dated October 9, 1946, follows:)

OCTOBER 9, 1946.

Dr. MORRIS FISHBEIN,
Editor, Journal of the AMA,
Chicago, Ill.

DEAR SIR: The board of directors of the newly organized Cooperative Health Federation of America, whose inauguration was featured by an editorial in the Journal of the American Medical Association of August 31, wish to set before your readers a statement of the federation's principles and aims. We trust that you will publish this letter in full, because we feel that your editorial did not accurately report our position.

The first principle upon which our federation is based is that patients have the right voluntarily to organize for the purpose of securing medical attention for themselves and their families.

Free association for any purpose not inconsistent with the public interest lies at the root of our liberties. Does the American Medical Association hold that the organization of consumers to obtain physicians' services is "inconsistent with the public interest?" We cannot believe that it does. Yet, we find its constituent societies in a number of States sponsoring and supporting legislation that pro-

ress per-
enacted,
ave the
nopolies.
of these
to give
nciently

re plans
fectively

ds, they
cal care,
deration
re well-
ties and
patient
ation of
close co-
ose who
needs of
It has,
combina-
demon-

In plans
ject the
r knowl-

improve

In summary, the Cooperative Health Federation of America believes that medical service is as proper an object for organization by patients as by doctors. We do not claim perfection for our plans, nor do we think that change in the method of paying for medical care will automatically and of itself alone immediately usher in the millennium. We have had wide practical experience in the organization of health plans and do not look for miracles. But we are intent on improving the distribution of the medical arts and sciences, and we believe that we have found one valid answer to the problem in voluntary consumer organization.

Sincerely,

Cooperative Health Federation of America,
Geo. W. Jacobson, *Secretary-Treasurer.*

Mr. Hansen. This is a companion statement of the statement of the things that the federation stands for in relation to the health and medical care program of the needs of medical services. It is a statement of the things that we believe in, and it is out of this belief that we have formulated our policy statement on standards for national health legislation.

While some of our member plans—speaking now of the Cooperative Health Federation—have been in operation for going on 20 years, by and large, the voluntary approach to a distribution of medical care on the prepayment basis is in the pioneering stage. While the prepayment method of obtaining medical care has been eminently successful in many parts of the country, we realize that voluntary action alone cannot solve the crying health needs of the whole population in any reasonable period of time.

Historically, all cooperatives favor voluntary over Government action; however, good health for every citizen is a matter of domestic security. The huge problem of making modern medicine available to all the people at a price they can afford to pay, and equalizing that cost, can be solved only by the Federal Government in a plan which has universal application. The Cooperative Health Federation, therefore, favors a national plan of health insurance, provided that voluntary plans are adequately protected and encouraged.

This position was not arrived at lately. How to obtain more and better health services has been a topic of serious discussion in cooperative meetings throughout the country for many years past.

Cooperatives are organizations of people in all occupations, farmers, factory workers, clerks, professional people, and from every income bracket. They represent both producers and consumers in the rural and urban areas of America. We know all too well that city workers with their fixed incomes are not prepared to meet unpredictable costs of serious illness in their families.

Farmers and people in small rural communities have a far more serious problem. There have been all too few physicians available in rural areas, and to make the problem worse, there has been a trend in recent years for physicians to move away from rural areas into the urban centers. For example, a recent study of the situation in Minnesota reveals an increasingly steady flow of physicians away from rural areas into the four large medical centers. By the end of 1946, over two-thirds of all the licensed physicians in Minnesota were located in these four cities, Minneapolis, St. Paul, Duluth, and Rochester, whose population is far less than one-half of the entire State.

Minnesota is considered a medically rich State. It has an excellent medical school integrated with the Mayo Clinic, and modern medicine at its best is available to that chosen population of the State which is

ave the
naining
0; and

oject of
Minne-
red the
n could
n rural
sicians;
nedical

equires
ysicians
it was
rs pro-
number
se who
the GI
ocating
otal of
d more
is done
ommit-

Another alternative might be direct Government compulsion upon the physicians themselves, but this suggestion is as abhorrent to cooperatives as to physicians.

To correct the rural dilemma, then, voluntary action must be preserved in any national health insurance system. We stress one point in this connection. Truly voluntary plans should be defined and administratively considered as those in which persons in a rural community may freely set up, finance, and control the needed facilities and with which physicians may freely associate themselves upon terms mutually agreeable. This is the American way and the only way by which rural people will be encouraged to work together to solve their common problem.

Recent experience in many parts of the country shows that, now that the problem is understood, rural people are enthusiastically seeking ways in which to provide themselves with modern medical facilities. I might say in that connection that some 25 or 30 communities, without any encouragement or incentive furnished by anyone, have studied to form voluntary health plans in their communities in Minnesota.

A national health insurance plan which will make its funds available to such a voluntary organization would provide an effective means to sustain its facilities and thus bring the blessings of modern medicine to our rural people. Any national plan which designates a single agency, group, or organization through which the funds must flow would stifle and foreclose such voluntary action.

To reemphasize this point, if any national plan gives over the control of the funds to medical associations or to commissions or agencies, the majority of whose governing body is required to be composed of physicians, it would fail to protect consumer-sponsored voluntary plans now in existence and would discourage the formation of new plans. Bitter experience has demonstrated to us—I am talking about the experiences of our member associations in the federation—beyond any doubt that where medical men are given effective or exclusive control they tend to give primary consideration to their proprietary interest. Take, for example, the fact that of all of the proprietary hospitals in Minnesota, 24 in number, not one meets the standards or has the approval of the American College of Surgeons.

On the other hand, nearly all of the voluntarily supported, nonprofit hospitals and community hospitals comply with the requirements of the American College of Surgeons, and have the approval.

In some States medical associations have obtained legislation giving organized medicine control over all prepayment plans.

Senator Donnell. Did you strike out the words "exclusive and monopolistic"?

Mr. Hansen. Yes, that is not true in all cases. I do not wish to make that statement all-inclusive. I want to say that in some States medical associations have obtained legislation giving organized medicine control over prepayment plans. There are different types of control. Others require a majority of the Government board to be composed of physicians, and some require at least 51 percent of the physicians in the area to be participants. Over one-third of our States now have such laws enacted by efforts of the medical associations. In those States where medic-controlled plans are in operation we have seen two things demonstrated: (1) Only very limited, catastrophic-type pro-

emnity
is.
oment?
nonopo-
ration.
ony the
amiliar

olistic?
at says
ayment

ice bill,
nedicine
s?
missive
set up
nas just
senate,

it been

I think

raphy of a section, its economic make-up, and the temperament of its people, as well as the extent of willingness of physicians in a section to cooperate, all together will determine the type or types of voluntary plans which most of the people in that section will support. The cooperative movement therefore insists that in any scheme of national health legislation the type of voluntary plans must be left open for free determination by consumers on the local level and will require that to receive its support any bill must give full assurance on this vital point. Further, the cooperative movement will insist that there be protection for the participating physician from discrimination against him by organized medicine for any reason except professional incompetence and unwillingness to accept the conditions of the contract between the voluntary plan and the Government.

In the past there has been repeated discrimination against competent licensed physicians who chose, against the wishes of their local medical societies, to participate in a voluntary plan. In many sections of the country such physicians were ousted from the society, with the drastic result that they were denied admittance for their patients in hospitals and denied access to consultative services. The criminal conviction of the American Medical Association in 1943 by the United States Supreme Court—that is, the affirmance of the conviction—for such discriminatory practices has not been entirely effective and it still continues. If voluntary plans are to be protected and encouraged, the law itself must protect the physician who participates against unwarranted and often capricious discrimination by a governing board in a medical society. Experience dictates the urgent necessity of such a provision.

Any national plan, to have the support of the cooperative movement, must provide for decentralization of administration in order to bring the administrative agency as close as possible to the people receiving the benefits. Administrative stopping at the State level cannot adequately know and deal with peculiarly local problems.

It is with all of these foregoing considerations that we have come to the study of the so-called Taft bill, S. 545, and the so-called Wagner bill, S. 1320.

The two bills now under consideration are widely divergent in aim and method. The Taft bill is designed primarily to aid the States to establish medical care programs for families and individuals having insufficient income to pay the whole cost of hospital and professional service, and dental care programs for children of the same income group. At the outset we dislike a purely charity bill. We cannot see the justification of segregating American people in the provision of medical care according to their income status. Income certainly has nothing to do with the incidents of disease or accident.

Senator SMITH. For the purpose of ready reference, I assume the case you refer to above is the case of the *American Medical Association* v. *The United States*, 317 United States, page 519 and following, decided January 8, 1943?

Mr. HANSEN. That is correct.

Although we believe that Federal funds for grants to State health agencies are necessary if persons in the so-called medical indigent group are to receive necessary services, and we support this principle, we are opposed to S. 545. It is not a comprehensive national health program, universally available to all persons everywhere. The federa-

public
rpose to
message
S. 545
l health

bill, it
ation is
ceiving
can be
ulation,
ce with
on the

re from
vices, it

o work-
rvivors
relation
f wages

health
vailable

Mr. HANSEN. That is what I mean.

Senator DONNELL. There is no wording in the Taft bill that uses the expression "pauper's oath."

Mr. HANSEN. That is true.

Senator MURRAY. The expression comes down from ancient times, when a person who was poor was considered not a proper citizen, and was disregarded almost entirely. The entire concept of a person's having to come in and prove by taking an oath that he belonged to that class became very odious, hence the reference to it as the "pauper's oath."

It was well established, well known in many countries what the pauper's oath meant.

Senator DONNELL. The point I am getting at, Mr. Hansen, is that there is no mention in the Taft bill of the pauper's oath.

Mr. HANSFN. That phrase is not used in the bill, that is true. It would seem that in such a personal matter as medical care, we can be big enough as a nation to treat all Americans equal.

Another objection to the Taft bill is that it invites giving to the payees of moneys in the funds the control over expenditures. It seems to us elementary that this is not sound financial policy. It would be like giving control of Federal Highway Aid Funds to road contractors.

Specifically, we are opposed to legislative language which would permit, as we believe the Taft bill does, a State to contract with a medical society or other type of plan for the payment from Federal funds of insurance premiums to cover the cost of care of persons who, when ill, had agreed to seek care from the physician who will be paid from an insurance fund maintained under such voluntary agency auspices. We are opposed to subsidies from Federal funds in the guise of insurance premiums, and we are opposed to nonpublic agencies having responsibility under a Government contract to act for the Government in organizing and providing services to any group of individuals. Under S. 545 there is real danger of Federal funds being used as a subsidy to voluntary prepayment plans, sponsored by medical societies, since the bill provides for payment of such "insurance premiums" and the State Advisory Council set up in the bill would be composed largely of representatives of organized medicine.

Senator SMITH. Just a minute—a little earlier in your statement, on page 2, you stress very strongly your belief that a voluntary effort in the community level should be maintained in favor of experiments in voluntary plans of prepayment medical care. I do not quite see how you would keep those up under any plan you might favor, unless you did the very thing you are criticizing here.

Mr. HANSEN. The Taft bill invites and permits a contract to be made with the State Medical Association to administer and handle and expend the funds, and what I am saying here is that it is possible, under the Taft bill—in fact, we think it invites this procedure.

Senator SMITH. We invite the States to set up an over-all medical control, a State-Government affair, and take the responsibility.

You speak here of the Federal highway fund going to the road contractors. The same principle applies when we have our highway aid funds that clear through the State highway set-up. I mean it is the relation of a Federal-State affair. It is not the State medical association.

fect, if
nedical

ling us
t.
I com-

it was
ans.
ns is in

tage of
ount of
and the
Federal
nations
edicine.
ies and
merely
hrough
ain the
health
l custo-

slight reservations we have indicated, S. 1320 is acceptable to the cooperative movement. We support and urge the passage of S. 1320.

Senator SMITH. The question I want to ask at the moment is the way you contemplate working in the voluntary plans, while at the same time you criticize the control of the voluntary plans by whoever may set them up. Do you mean by this that you do not want any contract with group cooperative plans, for example?

Mr. HANSEN. No; I did not say that.

Senator SMITH. No; I did not think you meant that. I am asking.

Mr. HANSEN. No. I did not mean that. We think, as I said, that the type of voluntary plan should be left to the citizens on a local level, leave it wide open. We are willing to compete fairly and openly with any plans that any medical society may inaugurate and operate.

Senator SMITH. Of course, that is perfectly possible under S. 545 as well.

Mr. HANSEN. There would not be any funds for people who are not indigent. In other words, I have put the emphasis in my statement on the shockingly poor distribution of medical care in rural areas, specifically because the overwhelming majority of the 10,000,000 people who are in the movement in the United States are in rural areas, and in order for those people to get decent medical attention they must have, first, a modern medical workshop to invite a doctor, to induce him to come there and practice modern medicine?

Senator SMITH. You mean like a hospital?

Mr. HANSEN. Or medical center; it might have 5 or 10 beds and a couple of doctors.

Senator SMITH. That was contemplated in the legislation passed last year, the so-called hospital bill that was contemplated to advance aid and have the State develop medical centers, hospitals.

Mr. HANSEN. But that is inadequate, from a financial standpoint.

Senator SMITH. These things have to grow. You cannot make a full-blown rose all at once. You have got to plant the seed and grow the plant. It was not contemplated that the hospital bill would cover all these needs at once, but it was a step in the direction, feeling out what we needed and how to do it.

Mr. HANSEN. It is a fine law and a great help. I did not mean to say it was not.

To finish my point, in order for rural people to have medical care, modern medical care, they have got to have some incentive to set up a modern medical facility. They will do it, and they will do it enthusiastically, as they did in Minnesota, without encouragement in the 25 or 30 communities, like mushrooms coming out of the ground. They just started into it in their own community, formed an association, subscribed the funds to build a hospital. Some of them have not even heard of the Ball-Hill-Burton Act, and if those people can furnish themselves with that modern medical workshop through their own cooperative community effort, and if S. 1320 were passed and tax funds were available to sustain the operation of that health facility through good times and bad in the rural communities, we will have made tremendous progress in the whole field of distributing medical care to the American people. The most neglected people are certainly the rural people.

Senator SMITH. I do not quarrel with you as to the need of the rural people.

setting
The
carry

nesota.

health
entire
ay for
tax so
proach
is the
uished

ement
n. Its
ected,
rtedly
ge, in
it will
em of

xperi-

Senator SMITH. I am not saying that. I am just presenting the differences in our approach. You would make an over-all tax now, tax everybody to deliver services that could not be delivered for some years. That is the question that troubles me. I think the State approach by grants-in-aid is the more practical, and in my judgment the quicker method. But that is a matter of opinion, of course.

Mr. HANSEN. My opinion is exactly the opposite, and for reasons which I think can be proved in the history of insurance companies. I think if you will look at the history of insurance companies generally, their early history, you will find that they have had tough sledding for about the first 3 years. They needed subsidies in the way of contributed surplus by their stockholders and so on, and after they got risks set out broad enough they became solvent and actuarially sound. The same logic must apply to national health insurance. It would apply, of necessity. So, if it is spread throughout the whole population on a tax basis we are sure, as far as we can be sure, that it will be actuarially sound and will work.

Senator SMITH. Have you any data on how it has worked in foreign countries on that basis, where we have a practicable demonstration of how it works, both as to the recipient and the physician? I would be interested in any data along that line.

Mr. HANSEN. I have not studied the plan in other countries.

Senator SMITH. I have said right along, and that is in S. 545—I have no objection to any State, the State of California, for example, that would like to try it. I would like to see California try it or any State try it and see how it works and come back to us and tell us to start with that. An over-all national tax which is a reduction to pay roll—I think we would be going a little fast with the data available. I have not seen data that convinces me that it would work.

Mr. HANSEN. I think, for instance, if you will consider that with the different types of regions we have in the United States, the financially wealthy section in the Northeast, the comparatively wealthy section in the north-central part of the country, some parts of the West—those areas might well carry on the successful plan State by State, but we are here before Congress because we are thinking of the United States from border to border, and many Southern States simply do not have an economy which will support it. Their State taxation, with the Federal taxation as it could, comes to quite a burden for those Southern States, and the risk has to be spread from coast to coast all over the country and all of our people have to be included in order for the thing to be successful, and I think the State-by-State idea is unsound for that reason.

Senator SMITH. Well, in both our educational program, which we are considering now, and also in S. 545, I think we are contemplating the very thing you are talking about. There are some areas of the country that need special help and differences in their favor in the way of funds. That has been the understanding from the beginning of the program for the distribution of funds. That is a fundamental of the formula. That can be regulated, of course. I am having a special study made of that now, a distribution basis as between the wealthier States and the poorer States. I am not denying that difference, but I feel that the State approach, to begin with, is the right way to go at it, to see what we can do with it—challenge the States to set up their health organization to meet this need that we

hat is
n that
n that,
admit
relim-
umber
utions
asking
ds for

tuarial
in this

to see
could

ng ex-
ting to
way to
actua-
tors of
believe

and cooperation with the Communists and Socialists and every other subversive movement in the United States. I don't think they are having any real success with it. It makes little difference to me. It does not hurt me a bit, but I think that is very unfair and very unjust for this committee to maintain a person here in this building who will send out stuff like that.

I did not think the Senate of the United States would ever fall so low as that.

I will join with you any time in resenting any remark here imputing evil intentions to your ideas or thoughts or your proposed legislation. I think that we, too—the minority here—should have some sympathy, some help and some protection from that sort of thing.

I think we are running into great danger in this country. It is becoming so that anyone who sponsors or proposes a measure for the benefit of the people of this country is immediately jumped upon and accused of being a Communist. Are people to be led to think that all sound, liberal, or solid legislation that is being proposed in this country is communistic—because they read in papers that it is espoused by Communists and Socialists? I think that is very unfortunate.

Senator PEPPER. Especially this health plan, the doctors themselves call it socialized medicine instead of applying to it its true description. They call "propaganda" of course, anything that anybody says that had any part in it, that he was a collaborationist. It would be just as accurate to charge the sponsors of the other bill with being fascists. Nobody would welcome that. We do not want to make such a statement, so I think the chairman has set a good example that might go out all over the country. We are all trying to find the best method of getting health care.

Senator SMITH. We have tried to do that all the way through. We are trying to get results, and I am one of those who do not approve of name-calling anyway.

Senator MURRAY. Mr. Hansen, a few moments ago you were speaking about certain favored sections of the country being in a better position to sponsor and make effective the voluntary plan. Of course, that is very obvious. The eastern section of the country, for instance, New Jersey, New York, Pennsylvania—these other sections of the East—in fact, all industrial sections—have been subsidized in this country for many years, and in fact, for almost our entire history from the Civil War on.

They have had advantages that have been denied to other sections of the country. Other sections of the country have been exploited by them, have been drained of their wealth. In the depression period we had to bring hundreds of millions of dollars into my State that had been drained out through our economic system because of the subsidy that is enjoyed by the eastern sections. They have the tariff system which has protected them and allowed them often to charge excessive prices to the farmers of the country. They have drained the Western States of their wealth so we were unable to establish industry of any kind and thus to develop a balanced economy. They maintain that system still.

Now they expect those sections of the country to get along without any satisfactory health program. It seems to me we should think about that phase of American economic life. There is where most of

ountry
three

ver the
hat do
his bill
ul ones
.

during
giving

day as
nerica?

duties

y upon

ul.
tion of

Coop-

Senator DONNELL. Is that that many individual persons? Or is that families?

Mr. HANSEN. That is families.

Senator DONNELL. You deal now with families when you give us these figures?

Mr. HANSEN. Correct.

Farm Bureau Cooperative Association of Ohio, 52,000.

Senator DONNELL. When you started in, the first figure was 50,000?

Mr. HANSEN. Yes.

Senator DONNELL. That is the eastern part of the country there. What were those first two?

Mr. HANSEN. 36,000 and 52,000.

Central States Cooperative of Chicago, 25,000.—

that is the fourth figure.

Midland Cooperative Wholesale, Minneapolis, 200,000; Central Cooperative Wholesale, Wisconsin, 55,000; Consumers Cooperative Association, Kansas City, 160,000; Associated Cooperatives of California, 60,000; Pacific Supply Cooperative, Washington, 70,000; American Farmers Mutual of St. Paul and the Farm Bureau Mutual of Ohio—

together, 1,000,000 is the way they give it to me on the list.

Senator DONNELL. An even 1,000,000?

Mr. HANSEN. Yes; they write insurance, cooperative insurance.

Senator DONNELL. Where is that located?

Mr. HANSEN. The American Farmers Mutual is located in St. Paul. Minn., and the Farm Bureau Mutual is in Columbus, Ohio.

Senator DONNELL. A million families?

Mr. HANSEN. Yes; insured with those two large cooperative mutuals, operating in several States I might say, outside of those.

Senator MURRAY. That goes into the State of Montana?

Mr. HANSEN. Yes, sir; it goes through there, also in part of the East.

Then we have as an affiliated fraternal member the Credit Union National Association, with a membership of 3½ million families. They were in attendance and an affiliated member at the Cooperative Congress last September, but I am not prepared to say that their organization has carefully considered or passed individually or separately upon this bill, so they should not be included.

Then we have in the Cooperative Health Federation approximately—you want all the list?

Senator DONNELL. Yes.

Mr. HANSEN. Group Health Association, St. Paul, Minn., 83,000, I believe; yes, 83,000.

Community Hospital, Elk City, Okla., 7,200; Group Health Association of St. Louis, 400; The Two Harbors Community Health Center——

Senator DONNELL. What State is that?

Mr. HANSEN. Minnesota—

3,800.

Group Health Cooperative of Puget Sound, 1,200; Labor Health Institute, St. Louis, Mo.—

they have an approximate figure on this because they have just enlarged in membership—an approximate membership of about 5,000.

. Louis,

or you,

Health
Kansas
l Center,
o Health
ation of
000.

on, Mr.
,000,000
spect to

s Union

hese are
100,000.

figures,
to say
rvative.
ers Co-

Senator DONNELL. We will appreciate it if you will. I was going to ask you for one of these before we got through so it will be offered and placed in the record, with your approval, Mr. Chairman, at this point.

(Articles of incorporation and bylaws, Cooperative Health Federation of America, follow:)

COOPERATIVE HEALTH FEDERATION OF AMERICA—ARTICLES OF INCORPORATION AND BYLAWS

ARTICLES OF INCORPORATION OF COOPERATIVE HEALTH FEDERATION OF AMERICA

We, the undersigned, for the purpose of forming a cooperative association under and pursuant to chapter 397 adopted June 19, 1940, by the Seventy-sixth Congress of the United States, do hereby associate ourselves as a body corporate and do hereby execute and adopt the following articles of incorporation:

ARTICLE I. NAME

The name of this association shall be the Cooperative Health Federation of America.

ARTICLE II. PURPOSE AND NATURE

The purpose of this association shall be to engage in activities for the promotion of the health and well-being of its members and of the public; to provide facilities for improving the physical, mental, and moral condition of mankind, to aid and assist its members and other persons, groups, associations, corporations, and institutions now or hereafter engaged in furthering any of the purposes above named, and to aid and assist with its own means, or as agent, trustee, or representative of others, any such persons, groups, associations, corporations, and institutions in any such purposes.

The general nature of its activities and business shall be to provide, furnish, or arrange for educational material and facilities, promotional and organizational advice and services, technical and management advice and services, and such supplies, commodities, and equipment as may be desired or necessary; to engage in public relations; to conduct research; and to engage in any lawful activity related to any of the purposes named above.

For these purposes it shall have power:

(*a*) To acquire, purchase, hold, lease, encumber, manage, and sell any real or personal property necessary in or incident to its activities.

(*b*) To borrow money or property and to execute the necessary instruments therefor, and to receive gifts, endowments, bequests, and Government grants and assistance.

(*c*) To own, hold, and transfer membership in and share capital, bonds, and obligations of other associations and corporations, and while owner or holder thereof to exercise all the rights therein.

(*d*) To make necessary or desirable contracts, instruments, or obligations.

(*e*) To do and perform every act and thing necessary to the conduct of its activities and business for the promotion and accomplishment of the purposes set forth herein or permitted by the District of Columbia Cooperative Association Act, amendments thereto, or any other applicable laws.

ARTICLE III. PRINCIPAL OFFICE

The principal office of this association shall be in the city of St. Paul, Minn.; provided that its location may be changed when deemed necessary by the board of directors. John Carson, or his successor in office, at 726 Jackson Place NW., Washington, D. C., is hereby designated as agent for service of any legal process upon this association.

ARTICLE IV. DURATION

The time for the commencement of this association shall be the 1st day of October 1946 and its duration shall be continuous and perpetual.

tock and

associate

unincor-
board of
cles, the
member-

hospital
ntaining

policy;

t in the
by others
ining to

of entry
nbership
e bylaws
l annual
air, pro-

sociation,
ring the
ectors or
mbership

Elmer Richman, second vice president and director. Address: 1127 Pine Street, St. Louis, Mo.

Cecil Crews, third vice president and director. Address: 318 East Tenth Street, Kansas City, Mo.

George W. Jacobson, secretary-treasurer and director. Address: 180 North Snelling Avenue, St. Paul, Minn.

Ludwig Anderson, director. Address: 726 Jackson Place NW., Washington, D. C.

Winslow Carlton, director. Address: 70 West Wall Street, New York City, N. Y.

E. J. Loehr, director. Address: Saskatoon, Saskatchewan, Canada.

James L. Monroe, Jr., director. Address: Hale Center, Tex.

Addison Shoudy, director. Address: Seattle, Wash.

Charles Wilkinson, director. Address: Two Harbors, Minn.

All of the above-named officers and directors shall hold their respective offices and manage the affairs of this association until the first annual meeting, at which time not less than 11 directors, as provided in the bylaws, shall be elected. The first board of directors so elected shall divide itself by lot into two classes as nearly equal in number as may be, the term of the first class to be 2 years and the term of the second class to be 1 year; thereafter in succeeding annual meetings directors shall be elected for terms of 2 years.

Sec. 2. The first and succeeding elected board of directors shall, within 30 days following each annual meeting, elect from its membership a president, first, second, and third vice presidents and a secretary-treasurer, each of whom shall hold office for a term of 1 year or until successors are elected.

Sec. 3. The executive committee shall consist of the above-named officers plus such additional directors as the bylaws may prescribe. The board of dircetors may delegate any part of its authority to the executive committee. Any member of the executive committee who is unable to attend a meeting thereof may name an alternate director to serve in his stead with full authority in such meeting.

ARTICLE IX. BYLAWS

The first bylaws of this association shall be adopted by the above-named board of directors and may be amended in any special or annual meeting by majority vote of the members voting.

ARTICLE X. DISSOLUTION

This association shall be dissolved according to law; provided that after fulfilling the requirements of the law any surplus shall be distributed as a gift to one or more nonprofit groups, associations, or corporations having purposes similar to this association, as determined by the board of directors.

ARTICLE XI. AMENDMENTS

Amendments to these articles may be adopted by a two-third's vote of the members voting in any annual or special meeting.

In testimony whereof, we, the said incorporators, have hereunto set our hands this 8th day of September 1946.

In presence of Horace R. Hansen, Charles Marlies, M. Shadid, Elmer Richman, James L. Monroe, Jr., Charles M. Wilkinson, Cecil R. Crews, H. W. Culbreth, Dean A. Clark, Ludwig Anderson, Harry A. Becker, George W. Jacobson.

State of Ohio,
County of Franklin, ss:

On this 8th day of September 1946, before me, a notary public within and for said county, personally appeared M. Shadid, Elmer Richman, James L. Monroe, Jr., Charles M. Wilkinson, Cecil R. Crews, H. W. Culbreth, Dean A. Clark, Ludwig Anderson, Harry A. Becker, George W. Jacobson, to me personally known who, being by me first duly sworn, acknowledged that they executed the foregoing articles of incorporation as their free act and deed, for the uses and purposes therein expressed.

R. Stevenson,
Notary Public, Franklin County, Ohio.

My commission expires February 1, 1949.

of incor-
board of
ions for
er quali-

articles,
umber of
g to the
2,001 to
ns, $250;
eometric

who are
thereto,
include
nated as

$25, for
addition

funds to
e in any
buted or
ted upon

contain
rights of

members, in attendance thereat; provided, that when mail votes are counted a quorum shall be 51 percent. Mail votes may be included in the quorum total only on matters noticed in the meeting call; on all other matters, a quorum of 30 percent of the membership in attendance shall be required.

ARTICLE III. VOTING RIGHTS

SECTION 1. Only regular members in good standing shall be entitled to vote in any meeting. Associate members shall be entitled to a voice in any meeting of the membership but shall not be entitled to propose any action to engage in any parliamentary procedure, or to vote upon any issue or election.

SEC. 2. Commencing with the third annual meeting of the membership, regular members, in addition to one basic vote, each shall be entitled to additional votes in geometric ratio to the total number of its membership who are users of the services as defined in the articles of incorporation and these bylaws according to the following schedule: Between 1,000 to 2,000 persons, one vote; 2,001 to 4,000, two votes; 4,001 to 8,000, three votes; 8,001 to 16.000, four votes; 16.001 to 32,000, five votes; 32,001 to 64,000, six votes; and so on, in like geometric ratio. The total number of votes thus allotted to each member may be cast in any meeting by one or more accredited delegates, or by mail as hereinafter provided. A member shall be entitled to its full number of votes only when its membership fees then due are paid in full; except that if a member has paid at least $50 of its annual fee, it shall be entitled to one vote.

SEC. 3. Voting by mail shall be conducted in the following manner: The secretary-treasurer or any other designated officer shall send to the regular members a copy of any proposal, and a list of nominees for directorships, if applicable, to be offered at any meeting, together with a notice of the meeting at least 20 days prior to the date thereof. The mail votes cast by the members shall be counted together with those cast at the meeting only if such mail votes are placed in the hands of the secretary-treasurer at least 3 days before the meeting. Upon decision of a majority of a quorum in attendance at any meeting, any proposal may be submitted to members absent from the meeting for mail vote. In such case, the secretary-treasurer or any other designated officer shall forthwith mail to each such absent member an exact copy of the proposal acted upon with instructions that the ballot shall be returned within 15 days to be counted. The returned mail votes shall be counted with others cast at the meeting in determining the quorum provided in section 4 of article II, and the result of the voting.

SEC. 4. Any provision in the articles of incorporation or these bylaws referring to votes cast shall include those cast by mail: Providing, that if a member has designated delegates and has transmitted their credentials to the secretary-treasurer as hereinafter provided, such member shall not be entitled to vote by mail in that meeting.

SEC. 5. Before each annual or special meeting of the membership, a member should elect whether it will cast its votes in the meeting by delegates who will be present at the meeting, or by mail. If a member elects to vote by delegates, it shall send the credentials for its delegates to the secretary-treasurer at least 7 days before the meeting. In no case may delegates themselves vote by mail.

ARTICLE IV. DIRECTORS

SECTION 1. At least 7 days before the first and each succeeding annual meeting each member desiring so to do may place in the hands of the secretary-treasurer nominees for directorships. This plan of nomination of directors shall continue until at any annual meeting the total regular membership exceeds 35 in number. At such annual meeting, the members shall elect a committee of 3 persons other than directors, who shall make a study of the membership area for the purpose of proposing to the next annual meeting a plan of geographical districts, formed in such manner that the size of the membership organizations for each district is approximately equal. At the annual meeting in which such district plan is reported and proposed by said committee, the matter shall be placed near the head of the agenda for consideration. If adopted, the members shall then caucus and decide upon nominees for directors in such manner that nominations from one district shall not exceed that of any other by more than one, and the total does not exceed the number to be elected. In addition to nominations so made, nominations may be proposed from the floor and the members shall then proceed by secret ballot to elect a board of directors.

ers shall
hey may
r organi-
such ter-
board of
e newly
in like
e or less
in each
board be

business
gulations
officers,
ploy and
n and to

ent, first,
term of
n officers,
together
his term
st of the
tunity to

cuse for
tee shall

vacancy,
ce of the

mittees and councils as it deems necessary. All such committees shall be responsible to the board of directors. Nominees of associate members of this association may be appointed on such standing committees with full authority and vote. A majority of any standing committee shall constitute a quorum thereof and decisions may be made by majority vote of the quorum.

SEC. 15. Meetings of the board of directors, executive committee, and any standing committee may be held at any place within or without the District of Columbia.

SEC. 16. No officer or director for his duties as such shall be entitled to compensation, except actual expenses, unless upon vote of the members in any annual or special meeting.

SEC. 17. The board of directors shall cause an audit of the books and records of the association to be made at the end of each fiscal year and report the findings of such audit, together with a statement of the financial condition of the association, at each annual meeting. If the amount received by the association in any fiscal year is less than $10,000, such audit may be made by a committee of three persons appointed by the board of directors or executive committee who shall not be officers, directors, or employees. If the receipts exceed said sum, such audit shall be made by an experienced accountant. Within 60 days after each fiscal period a report of the financial condition of the association, sworn to by the president and secretary-treasurer, shall be filed with the Recorder of Deeds for the District of Columbia as required by law.

SEC. 18. A referendum on any action by the board of directors shall be conducted in the following manner: The board may refer any action to the membership for approval or disapproval by mail vote, provided that the action is referred within 10 days of the time thereof; and the board shall so refer an action on majority vote of the directors or on petition of 10 percent of the membership, provided, that the rights of third parties which have vested between the time of the action and the referendum shall not be impaired thereby.

ARTICLE V. OFFICERS

SECTION 1. The principal duties of the president shall be to preside at all meetings of the association, the board of directors, and the executive committee, and sign all contracts and other instruments.

SEC. 2. The first, second, and third vice presidents, in order, shall succeed to the office of president in case of death or disability of the president and shall discharge the duties of the president in his absence.

SEC. 3. The principal duties of the secretary-treasurer shall be to have general charge of the keeping of proper records of the proceedings in the meetings of the association, the board of directors, and the executive committee. He shall have the general custody of the books, records, papers, and moneys of the association and shall provide for the safekeeping thereof, provided that such of these duties as may be authorized by the board of directors or executive committee may be delegated to the executive secretary, provided that the secretary-treasurer retains supervision of the methods employed in the discharge of these duties.

ARTICLE VI. FISCAL YEAR

The fiscal year of this association shall be from July 1 to June 30.

ARTICLE VII. AMENDMENTS

SECTION 1. Amendments of the articles of incorporation may be proposed by a two-thirds vote of the board of directors or by petition of 10 percent of the association members. Notice of the meeting to consider such amendment shall be sent by the secretary-treasurer at least 30 days in advance thereof to each member, accompanied by a full text of the proposal and by that part of the articles to be amended.

SEC. 2. These bylaws may be amended, with or without notice, at any annual or special meeting by a majority vote of the members voting.

The bylaws as above were duly adopted by the first board of directors of the Cooperative Health Federation of America in meeting on this 8th day of September 1946.

GEORGE W. JACOBSON, *Secretary-Treasurer.*

s board
officers
erative
re not,

y, who

nber of

th the

erative

either
ersons:

o testi-
Health
lbreth,

Service in that list of six persons. He is also one of the incorporators of the cooperative, is he not?

Mr. HANSEN. Yes, sir.

Senator DONNELL. In that list of directors that you mentioned, was Mr. Harry Becker, Washington, D. C. He is first vice president and director of Cooperative Health Federation of America?

Mr. HANSEN. Yes, sir.

Senator DONNELL. Is he still an officer and director of that federation?

Mr. HANSEN. So far as I know, he is.

Senator DONNELL. Do you know him also to be with the Children's Bureau in the Social Security Agency of the United States Government?

Mr. HANSEN. I believe that is the department he is in.

Senator DONNELL. And he was also the president—and possibly still is—I am not sure—of group health here in Washington, D. C., is that right?

Mr. HANSEN. Yes, and it is in that capacity that he is on the board of directors.

Senator DONNELL. Group Health is the organization that is mentioned in the opinion of the Supreme Court of the United States in this case of *American Medical Association* v. *The United States* (317 U. S., 519)?

Mr. HANSEN. Yes, sir. I do not think Mr. Becker was an officer at that time, however.

Senator DONNELL. I am not sure whether he was, but he has been, possibly still is; I do not know about his now being, but he was at one time at any rate president of Group Health in Washington?

Mr. HANSEN. I think he still is.

Senator DONNELL. Who is the Washington representative of the Cooperative League of the United States?

Mr. HANSEN. Mr. John Carson, 726 Jackson Place NW., Washington, D. C.

Senator DONNELL. That is the address, 726 Jackson Place NW., Washington, D. C.?

Mr. HANSEN. Yes.

Senator DONNELL. Mr. Voorhis is the executive secretary of the organization, Cooperative Health Federation of America, a dual position?

Mr. HANSEN. Yes, sir.

Senator DONNELL. Was Mr. Voorhis at one time a Member of Congress?

Mr. HANSEN. That is true.

Senator DONNELL. From what State?

Mr. HANSEN. California.

Senator DONNELL. I think you indicated—I do not recall whether you said it in so many words, but I got the idea that you are not undertaking to appear here today as an expert in the subject of compulsory health insurance; is that correct?

Mr. HANSEN. That is true.

Senator DONNELL. You are a lawyer and you are representing your clients, and you are presenting the views of your clients—they may be your own views; I am not questioning that in any degree—but the point I am making is that you are not appearing here as a witness to right?

e ques-
ulsory

plans
empted

rticles
f com-

hether
which
Great

m?

ness.
cost of

Mr. **Hansen**. That is not literally true, because all taxes are compulsory.

Senator **Donnell**. That is what I pointed out in the course of my interrogation of Mr. Carey this morning; that is, that S. 1320 does, in your judgment, involve both a pay-roll tax and ultimately the resort to general taxation to provide any deficit remaining unpaid from the pay-roll tax?

Mr. **Hansen**. I understand such a financial policy must be considered.

Senator **Donnell**. And in favoring S. 1320 you are doing so on that theory?

Mr. **Hansen**. Yes, sir.

Senator **Donnell**. You referred to the Southern States, as to the burden that you feel they are not able to handle, as I understood it. I take it you are speaking as a matter of general knowledge, without specific, detailed economic study of those States; right?

Mr. **Hansen**. That is correct.

Senator **Donnell**. Now, your own State, Minnesota, has a very fine illustration of the success of medicine and surgery in this country, has it not, in the Mayo Hospital to which you referred?

Mr. **Hansen**. That is right.

Senator **Donnell**. One of the outstanding, if not the outstanding institution of its kind in this Nation. That is correct, is it not?

Mr. **Hansen**. I think so.

Senator **Donnell**. And, generally speaking, do you concur with the views of some of the witnesses, possibly all of them, that the medical profession has made an outstanding achievement in this Nation along lines of scientific advancement?

Mr. **Hansen**. There is no question about it.

Senator **Donnell**. I wanted to ask you very briefly about two of those inserts, if you could let me have them, please. One of them was No. 5; the other was the one just before that. I do not know whether you numbered it 4 or not.

Mr. **Hansen**. No. 6.

Senator **Donnell**. I take it these inserts were prepared subsequent to the preparation of your original statement?

Mr. **Hansen**. Well, the statement was prepared by me in collaboration with members of a committee designated by the board of directors, in line with the resolution and statement previously adopted, so that we have the insert that I neglected to put into my statement, that was called to my attention.

Senator **Donnell**. Do you have any objection to telling us how large a committee that was?

Mr. **Hansen**. No, sir. I believe it was a committee of five.

Senator **Donnell**. Scattered, from various sections of the country?

Mr. **Hansen**. Yes.

Senator **Donnell**. Were those individuals persons who had specialized in the study of compulsory health insurance, so far as you know?

Mr. **Hansen**. That was Michael Shadid, of Elk City, Okla., and Winslow Carlton, of New York, George Jacobson, of St. Paul, myself, and Miss Gwen Goodrich, of the office in Chicago.

Senator **Donnell**. Is Mr. Shadid a physician?

medical-
.
, if any,
erations

robably

dgment,

nnesota.
ade any
health

. As to

here is

want to express my appreciation of your very courteous responses to the questions and your willingness to answer that.

I am wondering if you have observed on page 17 of S. 545, in connection with this whole subject of medical-care services this language beginning at line 4:

> Any State desiring to take advantage of this title may submit a State plan for carrying out its purposes. Such plan must (1) designate a single State agency—

notice that "State agency" —

> as the sole agency of the plan or designate such agency as the sole agency for supervisory administration of the plan, providing that on or before 1949 such agency shall be the State health agency.

Mr. HANSEN. I have read that.

Senator DONNELL. Doesn't that indicate that the State agency, as for illustration, the bureau of health, the department of health, whatever may be the name, is contemplated, on or before 1949 to be the single State agency which shall, quoting the language of the bill, "be sole agency for supervising the administration of the plan"?

Mr. HANSEN. Well, that is during and after 1949. There is nothing in this bill to prohibit the State, under section 712, the one which we have been reading, to designate the State medical association as the single agency. It is for that reason we make our objection to this provision.

Senator DONNELL. I am not quite clear as to your point there. Do you mean that there is ambiguity as regards the "before 1949," or do you regard it as leaving it open until 1949?

Mr. HANSEN. Leaving it open after 1949.

Senator DONNELL. After 1949?

Mr. HANSEN. Yes.

Senator DONNELL. You construe this language to make it obligatory that the agency "shall be the State health agency"—you construe that to be applicable only prior to 1949? Is that your construction?

Mr. HANSEN. Yes, sir.

Senator DONNELL. I am glad to get your comment on that, and I may say to you in all frankness that I had previously observed myself that there was some ambiguity in my mind as to that language, and it is confirmed by your observation there. I may be wrong on this, but the interpretation I would put on it was that the intention was that by that time the agency "shall be the State health agency," that thereafter it shall be the State health agency. There may be some room for question as to the wording, and if that should be clarified, I should certainly be pleased to have it clarified.

You think that this simply means that up until 1949 it must be the State health agency, and after that time it may be any agency.

Mr. HANSEN. Yes, sir.

Senator DONNELL. And you base your view in large part—your view that the medical society could obtain control of this plan in a given State, the State medical association, upon your interpretation of that language in lines 10 and 11 on page 17?

Is that right?

Mr. HANSEN. Yes, sir. I want to make one further statement in connection with that and that is——

Senator PEPPER. What page is that on?

Senator DONNELL. Page 17, line 10.

r your

e State

versing

l make
y until

before
ency"?
ing to
nedium

ng the
egisla-

d drift
9, and
hat I

n I can

nguage

which the governor would probably expect to obtain—certainly the power of appointment of the State health agency ultimately resides, does it not, in every case that I know of, in the appointive power of the State, which ordinarily is the governor by and with the advice of the Senate. Is not that true?

Mr. HANSEN. That is true, and I can agree with you that the governor, the executive head of the State, would want to have medical men in the State health agency.

However, it is not necessary, in my opinion, to have the health agency of the State in exclusive control of licensed physicians who are members of State associations.

Senator DONNELL. You would not advise that Federal funds be administered by a group of private citizens who are not under oath of office of any kind, would you? Would you not advise that the administration of Federal funds which are distributed throughout the Nation should be in the hands of some officials who are not ordinarily under bond but are under official oath, rather than those funds be administered by private citizens who may be under neither bond nor oath?

Mr. HANSEN. I agree with that.

Senator DONNELL. I very much appreciate your responses, and thank you very much.

That is all.

Senator PEPPER. Mr. Hansen, I believe the last time I saw you was in Mannheim in the United States Army of Occupation. What was your position there?

Mr. HANSEN. I was chief prosecutor of the War Crimes Branch.

Senator PEPPER. How long were you in the Army?

Mr. HANSEN. Three years and five months.

Senator PEPPER. Now, I agree with what the Senator has so generously said about other Senators here and we are all indebted to you for the very fair statement you have given us about this matter, both in your prepared statement and orally. Your analysis of the bill has been very penetrative and very clear. On the last point, have you noticed any difference between the kind of contract which would be made under voluntary prepayment plans, and their administration under the two bills?

Mr. HANSEN. Yes.

Senator PEPPER. Do you find—would you tell us under which there is the greater possibility that, for example, the American Medical Association or subsidiaries of that association might be chosen as the exclusive group to render medical service?

Mr. HANSEN. S. 545 provides—at least, makes it possible for control by State medical associations over the administration of expenditure of funds—leaves it open to that.

S. 1320 provides that no agreement shall be made exclusively with any group.

Senator PEPPER. In S. 545 I find the provision on page 18, beginning in line 16:

> such program may also provide for the furnishing of such services to such families and individuals by means of payments (in the nature of premiums or partial premiums or reimbursement of expenses or otherwise) by the State to any voluntary health, medical, or hospital insurance fund, or other fund, operated not

ne whole

or other
providing
of other
vide such

c, more
ry coun-

of this
ich you

ve been

curred?

rpose of

articles

?

Mr. Hansen. We encountered what I would describe or have described publicly as vicious opposition.

Senator Pepper. In what way did they express opposition?

Mr. Hansen. We asked the legislature in Minnesota simply to put on the books an enabling statute which would permit persons to form membership associations under the nonprofit laws of the State.

Senator Pepper. Voluntary associations?

Mr. Hansen. Voluntary associations, in which each member would have one vote, regardless of the amount of contribution, which would be fairly democratic and cooperative, and permit that association to arrange with doctors for medical services on any basis mutually agreeable between the physician and the association, and set up health facilities that they needed, like they are now setting up hospitals, the same way in which we attempted to include this amendment. The medical association in Minnesota put a great deal of political pressure on the members of the health committee time after time when we came there with witnesses from various parts of the State, who traveled great distances, but the health committee was unable to obtain a quorum.

I remember one case in particular when I had some witnesses prepared to testify from the State Grange, the State Farmers Union, and ministers and others, and we were scheduled so that we had a difficult time getting there, and we could not get a quorum, and I went out in the hall and found three members who should have been there and provided a quorum, and each of them told me that the medical association, the hospitals in their area, and even the druggists, had put such pressure on them to stay away from voting on this bill that they said "if we go up there in that committee and you make us vote on it, we will have to vote for it, and if we do we are sunk politically."

That is what we ran into in both house and senate, and for that reason it was most difficult to report it out of the committee.

Senator Pepper. You say you encountered that opposition really, which you describe as "vicious" opposition. You said "vicious"?

Mr. Hansen. Yes.

Senator Pepper. Notwithstanding the fact that the plan that you people proposed for the State of Minnesota was a voluntary plan?

Mr. Hansen. It involved no Government funds whatever.

Senator Pepper. It involved no Government funds and notwithstanding the fact that you proposed to make mutually agreeable contracts with the doctors and hospitals?

Mr. Hansen. Yes.

There was no compulsion in any of it.

Senator Smith. What reason did they give for opposing it? I think the proposal was a reasonable one, the kind of thing I thought we could get groups together to work out voluntary plans that we are talking about.

Mr. Hansen. Frankly, Senator, they could not meet us logically upon the provisions of the bill at all, and they chose to use the tactics I have described.

Senator Smith. I am wondering what attitude physicians of the standing of Dr. Mayo would have. Was he a party to that opposition?

Mr. Hansen. Dr. Mayo did not appear one way or the other. I can tell you this, however, Mutual Health went to the Mayo Clinic in 1940—I was there—and talked with Mr. Howarton, the manager, and

would
y serve
ayment
ference
e State.
unfor-
ting in
ed cor-
w, and

ether a
le pro-
Mayos
ut and
sion to-
s some
to per-

ly will-
se it is
on law
ethical,
with a
act and

I think there are in certain areas some individuals, but I do not think, generally speaking, that there is a medical monopoly in America.

Senator MURRAY. I had reference to the Minnesota situation.

Senator SMITH. It may be locally, but I do not know anything about that, and taking your statement, there is no sense in the medical group trying to oppose it. I think what you are attempting to get is the group plan in effect.

Senator MURRAY. Are you familiar with the Medical Fence Act?

Mr. HANSEN. That is it; yes.

Senator MURRAY. You are familiar with that situation?

Mr. HANSEN. Yes; in Wisconsin.

Senator DONNELL. He has already testified, Senator—I do not know whether you were here at the time—that the Medical Fence Act does not create a monopoly, as Mr. Biemiller was under the impression it did when he testified the other day.

Mr. Hansen, I think correctly stated that the so-called Medical Fence Act was merely a permissive granting to the State society an authority, not the creation of a monopoly. Am I correctly stating it?

Mr. HANSEN. Yes, sir. It it quite easy to become confused on that point, and I could see how a layman could get confused upon it.

Senator MURRAY. This gentleman who was testifying here the other day was an expert in this field, had devoted 10 or 15 years of his life to it, was a member of the State legislature out there and was connected with all of the activities there that were involved in that Medical Fence Act. And he was formerly a Member of Congress here.

Mr. HANSEN. Yes; I know Andy very well. What that act did was to permit medical societies—and it said only "medical societies"—to set up voluntary plans and to operate them. It was a permissive enabling act for the medical society, but it did not specifically state that consumer plans would be unlawful. However, it amounted to that because the common law prohibition against corporate practice which violates the licensing laws would bar it anyway. So the consumers had to go in this session and obtain an enabling act for themselves, which they did, and I believe by this time it has been signed by the Governor.

Senator DONNELL. You made it clear, however, earlier in your testimony—I think you mean the same thing now—that the so-called Medical Fence Act did not create a monopoly; it still left the way open for the legislature to grant to anybody else the privileges that the legislature might want to grant.

All it did was grant permission to this society.

Mr. HANSEN. Yes.

Senator MURRAY. But the State legislature had not taken action along that line.

Senator DONNELL. It has now.

Mr. HANSEN. It has now—a couple of weeks ago.

Senator MURRAY. So at that time the Medical Fence Act had the effect of giving exclusive control of the situation in that State.

Mr. HANSEN. In the manner in which I have stated. It had that practical effect.

Senator DONNELL. Just a minute; I respectfully disagree that it had that effect. What it did was grant permission to one society which it had not granted to others, and subsequently granted to others.

on-law
bstacle
cleared
couple
form a

thing.
der the
nferred
in the
e State
her did

having
d sub-
ss than
on co-

-not to
in this
whether

esident

Graduate Nurses, Inc., addressed to Senator James E. Murray, dated July 1, 1947, endorsing—containing a resolution adopted by the National Association of Colored Nurses endorsing S. 1320.

Senator SMITH. I might ask the Senator if he will yield just a moment, because, apparently, it was anticipated that the Frothingham letter was to be introduced today sometime and I have a letter from the secretary and general manager of the A. M. A., Chicago, as follows:

> It has come to my attention that a letter from Thurman Arnold, Esq., to Dr. Channing Frothingham, chairman, Committee for the Nation's Health, Inc., 1790 Broadway, New York 19, N. Y., dated July 2, 1947, has been introduced as part of the record of the hearings on S. 545 now being held before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. That letter undertakes to call into question the good faith of the American Medical Association in its efforts to promote the health of the people of the United States. I respecfully request that this communication also be made a part of the record.
>
> The American Medical Association, now 100 years old, was organized "to promote the science and art of medicine and the betterment of public health." It has endeavored to do so to the best of its ability by stimulating progress in medical education, by efforts to assure the purity and potency of medicinal preparations and the therapeutic value of apparatus, by exposing quack remedies and charlatans, by promoting national medical research, and by many other methods, including fostering and development of prepaid voluntary medical-care plans.

I respectfully request that this communication be introduced in connection with the other letters offered by the Senator from Florida.

(The letters referred to follow:)

ARNOLD, FORTAS & PORTER,
Washington 5, D. C., July 2, 1947.

DR. CHANNING FROTHINGHAM,
Chairman, Committee for the Nation's Health Inc.,
New York 19, N. Y.

DEAR DOCTOR FROTHINGHAM: Your letter of June 27, 1947, asked me for my comments on the Taft health bill, S. 545, with particular reference to its "restraint of trade and monopolistic implications." In answering your request, I am not writing as the former Assistant Attorney General who prosecuted the case against the American Medical Association, but as one who has always fought monopoly and monopolistic tendencies to such an extent that I am still referred to as "the trust buster."

I would like to break down your inquiry into two specific questions:

I. What monopolistic practices and tendencies exist today on the part of the American Medical Association and the State and county medical societies which, taken together, constitute "organized medicine"?

II. Would the Taft bill promote or restrict such monopolistic practices and tendencies?

I. As to the first question:

(*a*) I have long felt that organized medicine has utilized agreements, boycotts, blacklists, suspensions, and expulsions to prevent or impede physicians from participating in plans which would make medical services more widely available at less cost to patients. Under the Code of Ethics of the A. M. A., a county medical society may discipline and even expel a doctor who has entered into economic arrangements which the society considers "contrary to sound public policy." The medical society sets itself up as the judge of what is "sound public policy."

Expulsion or even suspension from a medical society is a severe penalty, especially since it ordinarily deprives a physician of staff membership in any hospital. In the case of a surgeon, this may destroy his practice. Thus the medical societies have assumed power over the practice of a profession licensed by the State, and over the civil rights of American citizens. Such a power goes far beyond that of a private club to control its own membership. In my opinion, such power is an exercise of a public function and should be subject to public scrutiny and, when necessary, to court review.

A physician may be brought up for discipline before a committee of doctors that might include his chief competitors in his private practice. In our civil

s might
not per-

ation v.
he way
e plans
lical so-
control
armers,
t plans

f financ-
re paid
or their
rference
medical

a white
council
. M. A.
its re-
medical
ate, the
medical-
nted its
s which
d other

opolistic

and the

of the Nation's largest minority, the Negro people should be of particular concern to the entire country, be it therefore

"*Resolved*, That we strongly urge the passage of 'The National Health Insurance and Public Health Act of 1947,' S. 1320, without discrimination as to race, creed, or color."

We respectfully urge its inclusion in the record of the Senate Subcommittee on Health.

We wish to express our sincere appreciation for your efforts in behalf of legislation which will insure greater health benefits for all of the people of our Nation.

Respectfully yours,

ALMA VESSELS, R. N.,
Executive Secretary.

AMERICAN MEDICAL ASSOCIATION,
Chicago 10, July 9, 1947.

Hon. H. ALEXANDER SMITH,
United States Senate Building, Washington, D. C.

DEAR SENATOR SMITH: It has come to my attention that a letter from Thurman Arnold, Esq., to Dr. Channing Frothingham, chairman, Committee for the Nation's Health, Inc., 1790 Broadway, New York 19, N. Y., dated July 2, 1947, has been introduced as part of the record of the hearings on S. 545 now being held before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. That letter undertakes to call into question the good faith of the American Medical Association in its efforts to promote the health of the people of the United States. I respectfully request that this communication also be made a part of the record.

The American Medical Association, now 100 years old, was organized "to promote the science and art of medicine and the betterment of public health." It has endeavored to do so to the best of its ability by stimulating progress in medical education, by efforts to assure the purity and potency of medicinal preparations and the therapeutic value of apparatus, by exposing quack remedies and charlatans, by promoting rational medical research and by many other methods, including fostering the development of prepaid voluntary medical care plans.

The intimation, implicit in Mr. Arnold's letter, that in those efforts the association, or any of its constituent or component units, have been motivated by a selfish or improper interest or that they have not had as an impelling objective the betterment of the health of the people, stems either from a lack of obtainable knowledge or from a disregard of knowledge actually possessed.

Mr. Arnold is quite correct that the council on medical service of the association has established "standards of acceptance for medical care plans" and that it has granted its seal of approval to a number of such plans sponsored by medical societies that have met the standards so established. Plans developed by other groups must meet the standards established by the council if they are to receive its seal of approval and a study of such other plans is now under way.

As to whether or not the enactment of S. 545 would tend to "increase the powers and the monopolistic control of organized medicine," which Mr. Arnold asserts it would do, the association has sufficient confidence in the integrity of the sponsors of the bill and in their sincere desire to promote the public wellbeing to be convinced that no such result is intended nor will any such result ensue if the bill is enacted. Mr. Arnold is simply seeing implications in the bill not warranted by its provisions.

Sincerely yours,

GEORGE F. LULL.

Senator DONNELL. With the Senator's consent, at this point, while this citation is already in the record, I think it will be well, for convenient reference, to again insert it, with reference to the case to which Mr. Arnold refers, namely, the *American Medical Association* v. *the United States*, being (317 U. S. 519).

Senator PEPPER. Yes; I think we should have it. I ask to insert in the record an article entitled, "Health Means Plans and Dollars" with

ational
gazine.
letter.
among

, higher
ectancy
ountry;

maga-

pages.

r Our

y of our
to make

e badly
nent on
olution.
d by the
from a

young Americans were unfit for military service for medical reasons has hushed our big talk about national health standards.

It's not primarily the doctor's fault that protracted illness and preventive medicine are so expensive, although it is a fact that organized medicine, through the American Medical Association, has demonstrated a minimum of social awareness in facing the mounting medical crisis.

But the individual practitioner usually is too busy with his never-ending responsibilities to think about broader medical issues. He carries an appalling load. In most cases the family doctor has fully earned the respect and affection which millions of Americans have for him. He has a habit of quietly scaling down bills for needy patients and carrying a load of charity cases without talking about it.

So many doctors have concentrated in the cities that demands on country and small-town doctors are proportionately higher. These small community doctors are often the ones with poorest facilities, largest practices, and lowest incomes.

The main effort to bridge the economic gap between patient and doctor has been through voluntary group insurance plans as a substitute for the fee system of payment. During the last two decades many Americans have got partial coverage against sickness through one of these plans.

But they have three fatal defects: They don't offer adequate coverage; they have proved too expensive for lower-income groups; and they don't include enough people.

Like most commercial health insurance policies, group insurance plans tend to restrict services and to neglect thorough treatment. Some group plans provide only hospitalization for limited periods, but over half our medical bills are for treatment given outside of hospitals. Less than 5.4 percent of the population has insurance for physicians' services, and about 2.5 percent have complete home, office, and hospital coverage. Only 1 American out of 4 has any kind of health insurance at all.

Many of people who have had experience administering group health plans say that these are only a necessary stopgap in the absence of a national health plan.

There are signs that the tide is setting in the direction of such a national program as a logical extension of social security. Opinion polls show a majority in favor of pay-roll deductions to provide national health insurance. And in the last Congress Republicans and Democrats joined to provide Federal funds for the construction of more hospitals and clinics, and for treatment and research in mental health and other fields.

Congress hasn't acted on the problem of providing medical services for those who can't afford them. But it may do so during the present session. Senator Robert A. Taft (Republican), Ohio, has revised his health bill, and reintroduced it, with the support of the AMA. Given the Senator's influence and the Republican desire to win votes from those who would benefit by the measure's provisions, chances for this bill look pretty good. Its main provisions:

> Coordination of civilian Federal health functions in a new Federal health agency.
>
> Appropriation of $200,000,000 yearly to assist States in providing medical care and hospital services for individuals and families unable to pay for them.
>
> Cash contributions by States at least equal to the sum advanced from the Federal Treasury.
>
> Approval of State programs by the Surgeon General, with appeal to a national health council in event of disagreement.

Enactment of the bill, according to its proponents, would probably make some basic medical services available to the poorest 20 to 25 percent of the population; opponents say only 10 percent.

Critics of the bill object strongly to a provision that applicants would have to prove their inability to pay. Too many States require a means test as proof of this inability to pay. This is a throw-back from the concept of social security to that of public charity. It seems needlessly humiliating, say the critics, that sick people should have either to exhaust their savings or stigmatize themselves as paupers to obtain emergency medical care.

The Taft bill also minimizes basic public interest in good health for everyone. We do not maintain schools only for those who are too poor to go to private schools, nor libraries for those who are too poor to buy books. Why offer medical care to the indigent, and exclude middle-income families for whom, also, medical services are too expensive?

Another criticism is that the Taft bill, by providing only emergency relief, forestalls any attempt to combat disease on a Nation-wide scale. Some doctors

eration,
Nation-

he Taft
on nego-
as cash
use this

new or

, differs
But by
ect.
Taft bill
cts, the
cheaper
ore com-
clauses

tration-
by a 3
general

Surgeon
n would
s would
ayments
ce on a
mpletely

tor also

Senator Murray introduced here, S. 1320, and Senator Murray is a Democrat and Senator Taft a Republican, but I can state there are differences of opinion in my own Republican Party on the questions concerned, and I know there are in the Democratic Party, but I have here given to me by a friend of mine a copy of a letter from Dr. R. B. Robins, Camden, Ark., which he suggested that I insert in the record to show his view at least. This letter is addressed to Mr. Gael Sullivan, executive director of the Democratic National Committee.

Dr. Robins is a member of the Democratic National Committee, the national committeeman from Arkansas, and he writes under date of July 2, 1947:

> DEAR MR. SULLIVAN—
>
> I have your bulletin of June 21, 1947, in which you continue to urge the idea of compulsory health-insurance legislation. To me and the people in my section of the country, this is a very repulsive project of the Democratic Party.
>
> It is very well known that this is the brain-child of such radical social reformers as Michael Davis and Isidore Falk, who would like to see our democratic system transformed into a totalitarian system.
>
> It seems to me that it is high time for the Democratic Party to stop pushing the philosophy of bureaucracy in our country. The present program seems to have as its ultimate object the destruction of the principal of self-reliance of the American citizen and making him more and more dependent upon the central Government. This leads to the loss of freedom as it has in all of the nations which have tried it.
>
> The tax gatherer this year will take more than one-fourth of our national income. Yet, our party continues to try to push programs that will increase this. The national health program which you are advocating is a compulsory program. There is no choice. It would build one of the greatest bureaus in the history of the world—a multi-billion-dollar bureaucracy.
>
> I would like to see the Democratic Party get away from the philosophy of Government paternalism and get back to the basic principles that made this Nation great.
>
> I am looking forward to seeing you next Wednesday.
>
> Sincerely yours,
>
> R. B. ROBINS, M. D., *National Committeeman.*

Senator SMITH. I am merely offering this because of the suggestion sometimes made that all the criticism of this approach comes from the Republican Party, and I just want it to appear that there is a difference of opinion among Democrats as well as Republicans, and this evidence is from a member of the Democratic National Committee, addressed to the executive director of the Democratic National Committee by Dr. R. B. Robins, Democratic national committeeman for Arkansas, Camden, Ark.

So it appears that we are approaching the subject, I might say, from a bipartisan standpoint, and we are trying to solve the problem, and we have different points of view in both parties.

Senator PEPPER. I guess we will probably find that a lot of Democratic doctors are against S. 1320 and a lot of Republican workers and farmers are for it.

Senator SMITH. Mr. Hansen, we appreciate very much your coming and thank you again for the fair way in which you have presented the matter.

Mr. HANSEN. I appreciate the attention, the courtesy, and good humor of the committee.

Senator SMITH. I understand that Mr. Joseph Louchheim and Michael Davis, who were to be here today, will be here tomorrow morning.

day I
sation
n that
k into

e, and

9:30

,
D. C.

a. m.,
Donnell

per.

morning
of the
y much
attend
t which

Senator DONNELL. Will you proceed, Mr. Lasker?

Senator MURRAY. I might add, Mr. Lasker, for many years you have been interested in the health problems of the Nation, have you not?

Mr. LASKER. I have been interested in the general health problem, having been attracted to that humanitarian problem through facing health problems not only in my own life but in my own family.

Senator MURRAY. And you are appearing at the personal request of the sponsors of this legislation?

Mr. LASKER. Oh, yes; I had no idea of appearing until I was asked to.

Senator MURRAY. All right.

Senator DONNELL. Proceed, Mr. Lasker.

Mr. LASKER. When first invited by members of your committee to testify on the various national health bills which you are now considering, I was hesitant to accept because, although I have long been deeply interested in these measures, I could not quite see where I qualified as an expert. While my presence here today evidences my own judgment that I do so qualify, I think it is important that I outline to you the reasoning which brought me to that judgment and the limitations of my "expertness."

Certainly, I cannot qualify as an expert on the technical, clinical, or scientific phases of medical practice. In that respect, it may be we are all in the same boat. Yet I think I do qualify on a number of other grounds. First, I am an expert sufferer, and thus qualified to plead the cause of others who, in their own persons or in the illness of family and close relations, have learned at first hand the agony of severe illness and the manner in which financial difficulties accentuated and sharpened that agony. In this sense, I am in no way unique. I am certain that all of you here can, in some way, match the experience I want to tell you, ever so briefly, about.

As a young man of very modest means, I married. A short time later my wife was taken with a grave illness—an illness that continued intermittently for 34 years, till her death. Within the first year of that illness, medical bills completely wiped out the small savings upon which we had so boldly ventured into matrimony. The blow was a staggering one to me. To my sick wife, it was an added burden, a constant worry and concern that no ill person should be asked to bear. I was fortunate in that my business ventures were successful. I was able to stay one jump ahead of the onrushing bills. As a young man in business in a period of economic expansion, I got by. But I know and you know that many millions of others, working on fixed salaries or struggling to make a go of small shops, farms, or limited small businesses, have inevitably gone under when subjected to the same devastating strain. It was only good fortune that saved me from being overwhelmed by the cost of a major medical disaster. Yet I know even then that I was among the very few so situated.

In speaking as one who has had to meet the bills, I am sure I speak of an experience common to us all. Certainly most of you, no matter how well off you may be today, have at some time and in some degree faced this same problem. It is this very knowledge, that we all are and have been sufferers from the inadequacy of provisions for meeting the cost of medical care, that inspires my great confidence in the members of this committee. No matter how strongly I may feel

does
gnize
e met
from

make
vidual

ng an
elf is
nt to
iting
You
tters,
ntless
nd to
nd in
all of

n the
olicy,
your
alify
have

serious illness. They can't afford enough medical care, nor can they afford to do without it. We can't afford to let them do without it.

I have heard the statistics as to the health of selectees explained away by very learned gentlemen. But all their wit has not been enough to erase the shock which all of us suffered when it was discovered that millions of our supposedly most healthy young men were in so poor a physical or mental state that they could not serve their country. Certainly, in the interest of the national security if not in the interest of the common welfare, we must make certain that the next generation does not suffer, when medicine can prevent it, from any such an overwhelming percentage of poor physical or psychological condition.

Now then, how can we do this? How can we achieve the purpose stated in S. 545's preamble? We seem to be in agreement on purpose and policy. But when it comes to method, we have two bills that seem to be at opposite poles. One proposes to utilize the democratic principle, to make it possible for all to pay for medical care by accumulating a pool of prepayments. The other proposes to allot Federal money, plus State money, to meet the bills of those unable to pay.

Now, it is generally accepted that our present national medical care totals some 4 to 6 billion dollars a year—no one knows the exact figures in view of inflation, but let's accept the 5-billion figure, for the moment. The bill, S. 545, for Federal subsidy of those unable to pay calls for $200,000,000 a year from the Federal Treasury; just about enough to take care of the medical needs of 5 percent of the people. If we allow for State matching to any degree and for partial payments for border-line cases, we will find we will be spending far more than $200,000,000, and we will still not take care of the problem of more than 10 percent of the people. Yet, in 1945, 69 percent of all American families earned less than $3,000 a year—97,000,000 people. And these people are the very backbone of a liberal and democratic state.

Way back in 1939, when $3,000 was a whale of a lot more than it is today, the American Medical Association published a chart which stated that families with incomes under $3,000 per year need help in varying degree to meet the cost of serious illness.

The first thing we'll have to face is the fact that $200,000,000 just won't do the job for those who can't afford to pay for medical care. It can serve 5, at most 10, percent of our people. It cannot begin to serve 69 percent, or two-thirds of our people. People with incomes between three and five thousand dollars simply can't afford serious illness. The average cancer case costs $1,000 a year.

As a businessman, it seems to me the purpose expressed in S. 545, "To aid the States to make available hospital, dental, and public-health service to every individual regardless of race or economic status," is not remotely covered by the appropriation provided for in the bill. If the stated purpose of the bill is carried out, certainly according to the American Medical Association's chart, those who would have to be helped in some degree with medical aid would expand the cost to many times the contemplated appropriation. Unless sufficient funds are appropriated to carry out the stated purpose of the bill, then the statement is but a mockery.

But suppose, even so, you decide to limit aid to the bottom 5 or 10 percent. What then? You'll take care, largely, of the chronically indigent—those, who, by and large, can never contribute much to our

ake our
t times,
ey will
sharks,
oly sick
he sub-

cal care,
surance
d draw
ut then,
, called

terstate
y, that
ne same
and the
end of
so op-
Medical
"social-
nd the
on the
ny food

have to provide for additional care—the care the people need but cannot now afford, for lack of the means to pay.

The carrying out of the purposes of the national health-insurance bill won't cost the people, through the Federal Government, anything remotely like 4 or 6 billion dollars, added money. True, the people, all the people, will pay taxes to the Federal Government to cover the cost of the insurance. But much of that money will come right from where it now comes, from the people who meet the medical bills today.

It has been said that there will be some time lag, after we begin collecting the tax for medical care insurance, before adequate medical care will become available to all people at all places. Obviousy, removing the financial barriers which now dam up the public demand for medical care will not cause a shortage but will bring to light the shortage of physicians and medical care facilities which now exists in some areas. But surely it has never been the American way to refuse to march forward to a better and more expansive life because we have to face obstacles on the way.

But before not too long, I think we will find our cost of sickness insurance falling. Because people will be going to their doctors early. Consider cancer. It has been reliably calculated that 17,000,000 Americans now living will die of this disease if we do not find new or better ways of curing it. Before they die, they will suffer many months, often many years, of ceaseless torture and incredible expense. But many types of cancer, caught early, are curable. If we can make it possible for people to detect and treat cancer in its early stages, we can not only save the lives of nearly half who now die—important as that will be—but we can also save the expense of their chronic, long-drawn-out illness.

The same is true of heart disease in many cases and of a score of other illnesses. Prepaid insurance will put a premium on preventive medicine, and that will hold costs down while vastly increasing the well-being and the productivity of millions of people.

I think that we have now covered the essential difference between these two bills. S. 1320 proposes to help the people to pay for their own medical care. Not so with S. 545. We already have one tremendous group of our citizens, the veterans, properly covered by a system of socialized medical care, paid for entirely out of general Federal Treasury funds. But do we want to extend that system of subsidy from the general Treasury funds to millions more, without responsibility and without contributions from the people? If times of stress, such as we experienced in 1932, ever come again, the beneficiaries under S. 545 would multiply beyond any present concept, and constitute a burden on the Treasury when the Treasury could least afford it.

I have stressed the so-called practical side of these bills at length. But a far more important side, as I see it, can be tersely covered. I want to bring my remarks to a conclusion with a plea that this committee report out at this session, and that this Congress at this session pass a bill truly providing for prepaid medical insurance; a bill which will guarantee medical care to all, with patients choosing their own doctors and doctors choosing their own patients.

I plead for this on the basis of good business, good democracy, and true humanity. I plead with you to help America go forward medidustrial

tion Mr.

d he has
ng here,

since I
enefit of
iews.
isted by
lth, and
ous with
ering of

e people
nything

xpress a
S. 1320
part in
ate way

Senator Pepper. In other words, being a champion of free enterprise in this country, you say if the term "socialistic" is to be applied to S. 545 or S. 1320, it would be more appropriately applied to S. 545?

Mr. Lasker. That is right, but I want to define the manner in which I use the word "socialistic." I am not a Socialist. I am for the American system. I am opposed to socialism as a political creed. I am talking about socialism in its broad aspect. I do not want to use the word as "group baiting" or something like that. I am for public schools. Those are socialistic.

Senator Pepper. In a sense it is a service contract by the State without any direct contribution by the beneficiary?

Mr. Lasker. That is right.

Senator Pepper. For example, that same distinction would exist in our method of old-age assistance, which is paid for out of the Federal Treasury to the old people without the beneficiary paying anything directly back for it, as contrasted with our old-age and survivors insurance under which the worker would get the benefit, contributing directly out of every month's pay-roll check?

Mr. Lasker. That is right. I am not in favor of socialized medicine, except in limited fields, such as the socialized medicine we have for the veterans. The increasing cost for the veterans is in a way—and may be ultimately in a very large way—a burden on the Treasury, which was never contemplated when the first bill was passed.

Senator Pepper. Mr. Lasker, I do not want to ask you anything that would make you feel that you were required to speak immodestly of what you have done in any field, but it has been the practice here for the committee to inquire something about the background of the witnesses who appear here as having some bearing on the weight of their testimony to be given by the committee, and I do not believe you made such a statement at the beginning of your testimony.

Would you be good enough to sketch for us what has been your own business and public-service background, and next what has been your association in health?

Mr. Lasker. Senator Donnell asked my business background.

Senator Donnell. I think we would like to have it amplified.

I would like to have a statement where you were born, and what your early education was, and your experience.

Senator Pepper. It is personal and business.

Mr. Lasker. When it comes to the story of where I was born, catch your breath, and wait until I finish. I was born in Germany. I had seven brothers and sisters, two born before me and five after me, all seven born in Galveston. My parents were American citizens. My mother was born in Rochester, N. Y. My mother was ill of another sickness when I was on the way, and they had taken her to a hospital at Freiburg, Germany, to be sure I would be delivered in good shape.

I am a natural citizen of the United States, really born in Galveston, Tex., as far as I am concerned, but insofar as the Kaiser is concerned, I was born in Germany because when I was 18 years old he came to the place where my mother had stayed after my birth, he did not come in person but sent his emissaries.

Senator Donnell. Persona per alia and not persona per se.

Mr. Lasker. Yes; to see whether I would serve my term in the Germany Army.

orrent to
itler sys-
the same
c system.
of thing
ill under
f having
ilosophy

ardon me

you had

ore of an

nd high
, which I

ss a copy
editor, I

l at that
since has

ol" and

Now mind you, you brought this up. He asked them if they would give me a chance to learn advertising. My father did not know in those days that to a man on the reportorial end that was like asking him to be a pickpocket. They wrote back they would take me, they having the intention to keep me for 3 months at $10 a week, which would have cost them $125 and which would have liquidated the obligation.

I had a notion, I was not proud, that if I went to Chicago and then went on to New York at the end of 3 months—my mind and Lord & Thomas' had already met you see—I could get a little aid from my father, because I was not to get a very great salary. But I had a reportorial state of mind. In Chicago I asked for a definition of what advertising was so I would know at least what I had gotten into. In those days there was no one who could define it. There may have been 12 or 14 firms in the business at that time. I doubt if any of them did as much as $1,500,000 business, whereas, you know today advertising is one of the great industries of the country.

So I stayed on longer than the 3 months, seeking to find out what advertising was. It is a long story, but the definition was given me one day, or night, rather, by a man who had been a Canadian mounted policeman.

I was in my employer's office, Mr. Thomas, about 6 o'clock in the evening. At that time every building had a saloon in the corner. We did not know them then by the name of taverns. They were saloons. We worked from 8 to 6, including Saturdays, those days.

Senator Donnell. The newspaper fraternity is pricking up its ears at this point.

Mr. Lasker. I forgot about the newspapers being present.

Senator Donnell. Go ahead.

Mr. Lasker. I was sitting with my employer when a note was handed to him, which he read and passed to me and which read:

> I am in the saloon below. You do not know what advertising is. I do. If you want to know, tell the messenger who brings this note to come down and tell me to come up.

My employer threw it over and said, "There is a crank." All this was about 7 o'clock in the evening. Often we would stay overtime. Nobody paid us anything for this, but we liked our work.

By that time I liked it too, because I was in it as a reporter to find out what advertising was.

I said, "Do you mind if I see this man?" and he said "No." So the man, John E. Kennedy, the father of all modern advertising, came up and stayed until 2 or 3 o'clock in the morning.

Today there is no great impact in Galileo's theory—that the world is round. Nor in Newton's theory of gravity. But in their times, these ideas worked vast changes in men's minds. So it was with what unfolded to me that night.

He defined advertising as "salesmanship in print." Before that it was just thought of as keeping your name before the public.

As a result of that, although I came to stay only 90 days, I was like the man who came to dinner. I stayed with the firm 45 years, and I kept Kennedy to teach me, and I got others for him to teach, and from our office emanated the basic principles of the techniques of advertising copy for we published everything he told us.

Every
f adver-

ing, be-
ght into
erchan-
ne early
much of

e fields,
e in the

nent, no
perience,
d prob-
ne in the

e maybe
because
me. So
h I had
hey are

our youth. We had such terrible scandals in baseball I thought it was utterly essential that baseball be put out of the control of owners and independently controlled.

I have been on hospital boards, community boards, like the Red Cross. I will put the rest in as et cetera.

Senator PEPPER. Now if I may ask you, you have been active in aiding private research?

Mr. LASKER. Yes. I retired from business for that purpose. I have a belief that after one has had as fine a life for one's self as one wants, that what one made by serving the people, should, in a large measure, return to the people.

Senator PEPPER. I would not ask you to name the amount of your contributions, but would you just indicate whether you contributed sums that might be regarded as large sums of money to private research in the country?

Mr. LASKER. Oh, yes; some millions of dollars. That is my only business. Our foundation largely expends its money on medical research.

Senator PEPPER. What is the name of the foundation?

Mr. LASKER. The Albert and Mary Lasker Foundation, one of the smaller ones. We are very small. We do not have much money, and we have to look for bargains in medicine. We have to look for things that offer great promise in that way.

Mrs. Lasker and I, through the foundation, appoached a very small society that has been in existence for 30 years, and to which, 25 years before my sisters and I had given $50,000—the American Society for the Prevention of Cancer—and 3 years ago we went to them and proposed if they would nominate lay control for the executive board and change the name to the American Cancer Society, we would provide moneys for a national campaign of fund raising. It takes added funds for a national campaign, and we would have to have a campaign of national education on the subject of cancer. However, that cost comparatively little money. From having been in publicity myself and my wife also having been in related fields, with one of the young men that had once worked for me, we devised a campaign of publicity that caught the imagination of the Nation. Now in its third year the American Cancer Society has raised its goal of $12,000,000. Until we came into it, it raised only small sums, only once approaching a million.

Last year in its second year they raised $10,000,000, but more than that, they have awakened the country to cancer and what can be done about cancer.

Senator PEPPER. Mr. Lasker, what has been the total sum received from the public by the American Cancer Society since you have been connected with it?

Mr. LASKER. They have had three campaigns. I am not now connected with the society. My health being bad, I had to resign from the board, though I advise with them much as I did with clients in the advertising business. My wife took my place on the board, and in 2½ years they have raised $26,000,000, of which 40 percent has gone to research.

It would be interesting for this committee to know how we came to this great study.

My wife went to see Dr. Gregg, the head of the Rockefeller Foundation, and she told him that we were going into medical research in

we had
kefellers

Montana
ist.
ntana is
to help

nd that

l to find
s things
worthy,
Not even
ms that

nths we
e talk on
so many
urvey of
ll other

nnually.
re many

Senator PEPPER. That is the story I wanted you to tell, Mr. Lasker, because it shows the breadth of your background and understanding of your interest.

Mr. LASKER. I did not cover other things we are interested in. We are interested in supporting research both abroad and here in varying places.

Most of the grants our foundation gives, I presume 80 percent, are not to people who appeal to us because we feel people who have the initiative to appeal will find someone who will give them assistance. Rather, we look for fields where there is a lapse of work and give money to those we approach who we feel can do it.

Senator PEPPER. It is broad experience and intensive interest, which you have manifested with your time and money, that leads you to support a bill like S. 1320, which contemplates first doing a great deal in the field of preventive medicine, second, provides for increasing the number of doctors and technicians, and third, plans to aid the people under the Hill-Burton bill. Because you think S. 1320 approaches this great common objective is the reason you come to give your support to it?

Mr. LASKER. That is right, Senator. I think these is one other thing that leads me to be for this bill, and that is the amount of suffering I have seen among people who could not afford medical care.

I could recite one case after another that touches you and every one of us, cases where the sick do not go to the doctor in time either because they fear the expense or because of other strains and stresses, with the result, I think, we have more absenteeism in industries from sickness than we have from strikes. Yet, we get all "het" up about strikes, front-page news, but it is not front-page news about absenteeism through sickness. I do not know that I will do it, because I have not been well, but I am really thinking of starting a league of sufferers throughout the United States. I mean it, because that is the only term that expresses it.

I am just as sure that ultimately Congress will pass a bill like this as I am sitting here. They will pass it from the great unspoken upsurge of the people wanting an opportunity for health.

Then too, my concept is we will have better medicine; doctors will be more prosperous; and we will have a more productive Nation. I do not want to be coy, but if we are going to have to face an unfriendly nation of 250,000,000 people, and we have only 140,000,000, and they always keep ahead of us in population, our main hope of preserving ourselves is in the health of the people we have.

Senator PEPPER. Well, thank you very much, Mr. Lasker, for coming here. As one who happens to temporarily hold public office, and from whatever right that gives me to speak for the public, I want to thank you.

Mr. LASKER. Proper medical care for all means everything to all of us. I am not one of those who claim they do not get anything out of this struggle. I want to make this clear. I am not a professional "do gooder." I get much personal satisfaction out of sharing in this struggle. I have been impelled to action in this matter, in medical research and health, because of my belief that health is the very cornerstone in a strong democracy, such as ours. For ours is a liberal democracy, which is not only political, but is also a way of life inclusive of the economic and social aspects of our society.

ur coun-
the very
e philan-

e you are

pleasant.

ons, Mr.

particu-
ghly con-
ne merits

n society,
tween us

Senator DONNELL. May I give you an illustration?

Mr. LASKER. But I am not such a great believer——

Senator DONNELL. I want to illustrate the point.

Mr. LASKER. Yes.

Senator DONNELL. You referred to Dr. Gregg of the Rockefeller Foundation. You, that is, the Albert and Mary Lasker fund, have jointly financed the Committee on Research and Medical Economy, have you not, Mr. Lasker?

Mr. LASKER. That was done. I am just over a sickness of 2 years, which kept me 7 months in the hospital, and I am not fully acquainted with that. My wife attended to that.

Senator DONNELL. Without going into the details of it, you know as a matter of fact there was a collaboration between the Rockefeller Foundation and the Mary and Albert Lasker Foundation?

Mr. LASKER. In several things. I believe so.

Senator DONNELL. The importance of publicity was recognized, I take it, by that organization, the Committee on Research and Medical Economics, by the issuance of the report in evidence, entitled "Principles of Nation-wide Health Program," printed by the Committee on Research and Medical Economics, Report of Health Program Conference.

Have you seen that publication?

Mr. LASKER. No, sir.

Senator DONNELL. I call to your attention the fact that copies of this report are stated to be obtainable from this Committee on Research in Medical Economics at 1719 Broadway, New York.

Do you know whether Mr. Michael M. Davis is chairman of that Committee on Research in Medical Economics?

Mr. LASKER. I believe he is.

Senator DONNELL. Do you know whether or not Dr. Channing Frothingham is one of the members of that committee?

Mr. LASKER. Yes, sir.

Senator DONNELL. You know Dr. Frothingham?

Mr. LASKER. I only met him once casually.

Senator DONNELL. You know of the fact that Mrs. Lasker has been very active, and properly so, in the matter of health and related subjects, and is a member of the board of directors of another organization known as the Committee for the Nation's Health?

Mr. LASKER. Yes, sir.

Senator DONNELL. Do you know that Dr. Channing Frothingham is or has been until recently chairman of that committee?

Mr. LASKER. Yes, sir.

Senator DONNELL. I ask you if you know Dr. Ernst P. Boas?

Mr. LASKER. No; my wife does.

I said I was appearing as an individual. I am not appearing as a representative of the Albert and Mary Lasker Foundation.

Senator DONNELL. I understand.

Mr. LASKER. My wife's interest in this is in a very different area than mine. She is active technically. I have devoted myself in the last 2½ years to cancer and to the crystallization of opinion. Thus, I am not in close touch with that end.

Senator DONNELL. Mrs. Lasker, as you mentioned, is on the cancer board.

t I not
She is

ew Dr.
or the

r wife,

direc-

fices in

release
n, Inc.,
Iedical

ferred

ington

Senator Donnell. A film got out by someone for circulation through the motion-picture theaters, if it is a good film, and people are interested, attracts attention and has great influence?

Mr. Lasker. I do not know how much influence it has.

I wish the film people would do more on it on things of general interest. My quarrel is they do too little.

Senator Donnell. I take it you would regard that type of publicity as having a real value in national affairs?

Mr. Lasker. In our national discussions here?

Senator Donnell. Yes.

Mr. Lasker. If I were to go and ask one of the film companies, not that they would do it because I asked it, but because a private citizen asked it, to have a film on national health, I would be very careful to ask them to present both sides. I am always willing to be convinced myself. I always like to have both sides presented because I try to be on the side that will gain by the other side being discussed.

I feel if we could get a discussion on a wide basis on these two bills, there would be a great national upsurge for our bill, for the bill in which I concur.

Senator Donnell. You say "our" bill.

Mr. Lasker. I know, but I never wrote it.

Senator Donnell. Yet, have you not called it "our bill"?

Mr. Lasker. A Freudian error.

Senator Donnell. Have you been rather closely in touch with the authors of the bill?

Mr. Lasker. No, sir. So that there is nothing hidden, I sat at a dinner one night in my whole life with some of the authors of the bill. Other than that I have not met with anyone in connection with it.

Senator Donnell. The dinner to which you refer, Mr. Lasker, was here in Washington or in New York?

Mr. Lasker. Here in Washington.

Senator Donnell. Was it recently given?

Mr. Lasker. Yes, sir.

Senator Donnell. How recent?

Mr. Lasker. That is how I came up here.

Senator Donnell. That is fine. I wish I had been there too. It was a good dinner, I presume?

Mr. Lasker. Yes; the Statler did very well by us.

Senator Donnell. When was that dinner held, Mr. Lasker?

Mr. Lasker. I think maybe 3 weeks ago. I will give you the whole dark conspiracy, right in the limelight.

Senator Donnell. That is what I want. Go right ahead.

Mr. Lasker. My wife at the present time is, and has been since that dinner, quite ill and in bed with jaundice. I do not mean to say that the dinner gave her jaundice. I want to make no admissions.

Senator Donnell. Make no admissions. You may want to file a suit.

Mr. Lasker. I thank you for the guidance.

Senator Donnell. All right, go ahead.

Mr. Lasker. I was very disturbed. I knew something was brewing and she was coming down to the meeting of the executive committee of the National Health——

Senator Donnell. The Committee for the Nation's Health?

ley were
ation.

th, Inc.?

presenta-

2 laymen

n present

earful of
to check

she said

dinner?

Senator PEPPER. Before we leave the dinner, because that is one of the occasions we are always reluctant to leave, I recall the delightful company. Mr. Lasker was there just as a casual observer and spectator. He participated in no way in our discussions. He sat around and did not say anything until just at the close somebody said, We have a very distinguished visitor here, very observant and attentive, and he has not said much, let us ask his views.

Well, Mr. Lasker was in a group of people that felt they knew something about the subject. In fact, some of them thought they were really experts.

Senator DONNELL. Naturally Mr. Lasker made the best speech.

Senator PEPPER. He made such a moving speech that the sponsors drafted him to be a witness here and to give the Senator from Missouri an opportunity to hear him, and the next time we will invite you.

Mr. LASKER. I am sure they will never get me to another dinner unless you are present, and I am counting on your saving me from having to go.

Senator DONNELL. I think Mr. Lasker has given a most colorful and very powerful expression of his views. I can well understand how his views, as expressed, were very, very moving and impressive.

Do you remember whether Mr. Michael M. Davis was present?

Mr. LASKER. Yes, sir.

Senator DONNELL. Was Dr. Frothingham there?

Mr. LASKER. Oh, yes.

Senator DONNELL. The board of directors were there, or most of them?

Mr. LASKER. I do not even know, frankly. The heads of this committee were there.

Senator DONNELL. Yes.

Mr. LASKER. It was a dinner held after their respective meetings.

Senator DONNELL. Yes. Was Mr. Abe Fortas there?

Mr. LASKER. I think yes. I just got a nod that he was there.

Senator DONNELL. Now Mr. Lasker, I was going to ask you something about one or two of your observations in your statement this morning.

Mr. LASKER. Yes, sir.

Senator DONNELL. You mentioned at the outset "I cannot qualify as an expert on the technical or clinical or scientific phases of medical practice." I want to say I cannot either.

I want to ask you this, you mentioned in recent years your organization, your foundation, the Mary and Albert Lasker Foundation, has conducted research abroad?

Mr. LASKER. Where is that?

Senator DONNELL. I took a note of that. You stated——

Mr. LASKER. I stated that we had grants.

Senator DONNELL. What?

Mr. LASKER. Grants.

Senator DONNELL. What is that?

Mr. LASKER. Grants is where you give money to an individual or institution to do a particular piece of research.

Senator DONNELL. Perhaps I misunderstood. I thought in response to a question asked by Senator Pepper or Senator Murray you had said that.

Mr. LASKER. Had given grants. We conduct nothing.

t on. I
ufferers,
nerchan-

y.

it is, but
study of
n of the

would be

dergo an
in most
in most

y of the

e you on

Mr. Lasker. In our medical schools and so on, but I have seen and been enough with American medicine to know it is the best in the world, though it is far from being what it can achieve, and I believe that more medical schools and more medical experts will make American medicine what it should be.

Compared to the rest of the world it is No. 1, but compared with what America can do I am impatient with it.

Senator Donnell. You do think, compared with other nations, American medicine is superior?

Mr. Lasker. Not as is within the reach of most of the people; no.

I am differentiating between the practice of medicine and the ability to take advantage of it.

I think I can illustrate it this way. A few years ago I heard some doctors referring to their practice as business. On a few occasions I heard doctors say, "My business is driving me mad," or "I have too much business."

After I thought it over, I realized I should not be questioning that as the proper term. Medicine is both a profession and a business. Any operation where money comes in and goes out is a business.

So then I got to really contemplating the business end of medicine and I am convinced the business end of medicine, the distribution of the merchandise, is very very backward.

I do not quarrel with the medical profession. They are so busy rendering service, most of them at a great sacrifice to themselves, as evidenced by the fact a bigger percentage of doctors die from heart disease than any other group, they are so busy they do not have time to think of the question of distribution of medical care, and like all of us, if we are overworked, and we are in a vested situation, we shrink from anything new.

I think I covered that by my own reaction to the Pure Food and Drug Act. I now think that this act has, in a large measure, benefited the consumer of medicine.

In the United States there are 160,000 to 180,000 doctors, but there are 140,000,000 consumers. Now it is almost the only transaction where the consumer is considered out of turn if he says something about how the trade should be made. I am making bold to speak for those 140,000,000 consumers of medical care.

Senator Donnell. Mr. Lasker, what I particularly had reference to, and the question was whether or not you have studied yourself the effect which the German, the French, or the British system of handling health-insurance matters has had on the quality of medical service rendered.

Have you made any study of that?

Mr. Lasker. I could not dignify it by the word "study."

I think I am an informed man, and I must limit myself to the area in which I want to testify because it is only in that way I am competent.

On these other questions your committee will find witnesses, pro and con, or both, who will testify much better. I disqualify myself to answer your question.

Senator Donnell. Well, I take it that you did not assert, from what you have said this morning a number of times, that you have studied the effect of those various systems in those nations, and I

on the
hat?
e in the
ed any-
ot com-
y other
are the

ch I do

nk that

cal care

ot there
ve that
untries?
oo long,
on.
Associ-

In regard to the provision of service, you say in your statement, under the other bill before you, S. 1320, it calls for prepaid medical care, for buying medical care on the installment plan, with an insurance pool to which all would contribute and from which all would draw when the need arose.

Is it your understanding that S. 1320 enables all the people of the United States to draw these medical services?

Mr. LASKER. Well, up to a certain extent.

Senator DONNELL. Then everybody in the United States, you think, is covered by that bill up to a certain amount of service. Is that right?

Mr. LASKER. If they are within the group that pays in.

Senator DONNELL. You think it is only the group that pays in.

Mr. LASKER. Again I was testifying on the proposal. I have read them, but find both bills very difficult to understand. There were sections which if I were to reread them several times I still could not get clear. I read both bills and I may be clouded on some detail, but by and large the answer is "Yes."

Senator DONNELL. Yes what?

Mr. LASKER. By and large, yes, what I stated.

Senator DONNELL. That this is an insurance bill to which all would contribute and from which all would draw when the need arose.

Mr. LASKER. From your question, do you say I am assuming there may be some few exceptions?

Senator DONNELL. I might say, Mr. Lasker, there is some misunderstanding.

Mr. LASKER. I would be very glad if you would tell me.

Senator DONNELL. I am not qualified to state the exact percentage of persons who would contribute, or the actual percentage of those who would draw benefits.

It is my general understanding, and I am sure that either Senator Murray or Senator Pepper will correct me if I am grossly in error, but it is my understanding the bill contemplates about 85 percent of the public receiving benefits thereunder.

Am I approximately correct on that?

Senator MURRAY. It covers a lot, but the State may be able to cover in by contribution all those who are wholly indigent and unable to make any contribution whatever.

Mr. LASKER. Oh, no. I meant by saying that, people like myself might not be covered. I was speaking, if you noticed in the $3,000 group. I meant all within that group.

You took it out of the context and you might get a little off base.

Senator DONNELL. As I understand S. 1320, even though a man may have a fortune of a million dollars he pays in on the $3,000 income?

Mr. LASKER. That is right, but he might want further medical care than he would get under the bill. I would think it would cover the medical care of practically all the people up to the minimum amount.

Senator DONNELL. You had some difficulty in understanding this bill and the other bill?

Mr. LASKER. I have never read a bill in the Congress that I understood fully if it was more than 2 pages long.

ter they
hs they

ing this
United

percent

n to the
rovision

been a
on the
S. 1320,

ve bene-
others.
erstand

nade for
e needy

In other words, where you have individuals that are able to take care of themselves, this bill obviously, by the amount involved in the bill, does not contemplate payment to anybody, and that is amplified and corroborated by the language of the bill and a little later on where it is stated at page 18 of the bill therein envisaged will—

> Set forth a stabilized program designed and calculated to provide within 5 years—
>
> (*a*) hospital services, surgical services, and medical services for all those families and individuals in the State having insufficient income to pay the whole cost of such; and
>
> (*b*) periodic physical examinations for all children in elementary and secondary schools in the State.

The point I am making is I do not think the view $400,000,000 is not enough to take care of everybody justifies criticism of S. 545, because it does not contemplate that.

Mr. LASKER. In all good will, I now have to speak at a little length.

Senator DONNELL. Fine.

Mr. LASKER. I want to reiterate what I said in the statement, I am for every Senator interested in health. If we differ, we differ through differences of philosophy, but there can be no differences on facts and financing.

Senator DONNELL. Very well.

Mr. LASKER. If that paragraph means only what you say, I want to be so bold as to say the paragraph is a mockery.

Senator DONNELL. That is what you have said.

Mr. LASKER. That is what I have said.

Senator DONNELL. You do not understand S. 545 contemplates providing services to everybody in the United States?

Mr. LASKER. No.

Senator DONNELL. Indeed, you recall, as I have just read from the bill, page 18, the programs are to be designed for persons having insufficient income.

Mr. LASKER. My prime quarrel, if I may use the expression in good nature——

Senator DONNELL. Certainly.

Mr. LASKER. In S. 545 that the paragraph or declaration of its purposes is not at one with the rest of the bill, and I really think the sponsors ought to withdraw that paragraph to make the issue clear so it can be really discussed.

That paragraph expresses much better and in fundamental words, and in fewer words than I, as I am a rather longwinded man, what I should like to see covered. Bill S. 545 does not provide for that, because two-thirds of our people who cannot afford proper medical care are not covered by S. 545. Two-thirds of our people have their lives blighted because they cannot have preventive medicine. Two-thirds of our people are psychically upset, either because they do not know how they will get medical care or do not know how they will pay the bills when they get through, and while I favor the declaration of purpose in S. 545, only S. 1320 carries it out.

Senator DONNELL. I get your point, and I think your point is one that should be very carefully considered by the sponsors of S. 545, because if there is an ambiguity derivable from page 2 it should be removed.

e made it
vay. as to
I found
purpose.
d of bill.
aragraph

prepared
ted, does

you have
medicine
thirds of

have had
e one fol-

could not
ng there

months,

nen were

ries over his economic condition, would have gone to the doctor earlier and had himself taken care of.

It is for those people that I speak. I do not call them the little people, as the phrase is very often used, because they are not the little people. They are the big people of this country. A country that has not got a middle class, and a large middle class, particularly in the lower-income group, will never remain a democracy. I am firmly convinced of that. Those are the people who are the heart of this democracy. And unless we give them health and an opportunity to pay their way to health, we are not strengthening our democracy, at a place and at a time when there is a crying need for it, not only domestically but vis-à-vis our world relations.

Senator DONNELL. Mr. Lasker, do you think the bill should provide for treatment for a person afflicted, let us say, with tuberculosis?

Mr. LASKER. How is that?

Senator DONNELL. Do you think S. 1320 should cover treatment for a person afflicted with that disease, tuberculosis?

Mr. LASKER. Surely.

Senator DONNELL. Do you understand that this bill, S. 1320, does so provide?

Mr. LASKER. I have read the bill, you understand, but I have not deposited all provisions of it in my memory. Vaguely, I think it does. I can say this, Senator: there was nothing that either bill provides that I wasn't for. May I say that to you, because I want to emphasize it: there is nothing that S. 545 provides that I am not for. I am merely opposed to it on the basis of the statement of purpose, and that it does not carry out the statement of purpose. It is too little, to too few people, and in too few right places.

Senator DONNELL. Do you regard hospitalization as frequently being of great importance in the treatment of tuberculosis?

Mr. LASKER. You are getting into a field with which I am not too familiar.

Senator DONNELL. I mean aside from any technical aspects, you and I agree that it is important to have hospitalization for tuberculosis in many instances; is that correct?

Mr. LASKER. In many instances; yes.

Senator DONNELL. Now, I want to say first, in regard to your cancer illustration——

Mr. LASKER. Pardon the interruption, Senator, I am not quarreling with what is in S. 545.

Senator DONNELL. I am not talking about S. 545. I am talking about S. 1320.

Mr. LASKER. Yes, sir.

Senator DONNELL. What I want to understand or find out is whether it is your understanding that S. 1320, with respect to tuberculosis, provides for hospitalization. As you analyze the bill, does S. 1320 provide for hospitalization of persons suffering from tuberculosis?

Mr. LASKER. I do not remember that detail. I would not be able to speak expertly on it. I'm afraid I am not competent to testify with respect to that. Please don't embarrass me by asking me to.

Senator PEPPER. May I call Mr. Lasker's attention to a provision of S. 1320?

Senator DONNELL. Yes.

page 68
ates that
e States,

ction, pre-
nental dis-
nutritional
high mor-
specialized

Senator.
ker about

ent about
derstand
1320. It
e general
however,
y under-
ases, and
e follow-

sing serv-
n connec-

Senator DONNELL. Yes.

Mr. LASKER. Yes; I remember that very distinctly. I want you to set me right.

Senator DONNELL. Yes, I will.

Mr. LASKER. Because I don't agree with your interpretation of what I think.

Senator DONNELL. If I could just finish this thought I am on now, Senator Pepper called attention to page 68, in connection with the provision under "Grants to States for health services." When it gets down to these matters of mental diseases, cancer, heart, and degenerative diseases, dental disorders, nutritional deficiency diseases, and so on, control of tuberculosis for some reason under S. 1320, as I see it, goes over into the theory of S. 545, and does two things.

In the first place it provides for a grant to States which is such as S. 545 does, and in the second place I think it provides for the administration of the States' grants somewhat along the general line of charity for needy persons who are chronically indigent, so to my mind it should be pointed out in connection with the comment made by Senator Pepper that title III, which is located at page 68, goes right directly into the theory of S. 545.

Now, Senator Murray was fearful that I might overlook some part of this. I will call your attention again to these earlier pages.

Mr. LASKER. I told you I have no quarrel with S. 545, save for one paragraph.

Senator DONNELL. That is the paragraph in the declaration of purpose?

Mr. LASKER. Yes. It is inherent that the things covered in S. 545 have to be covered in a comprehensive bill. My quarrel with S. 545 is that it is not comprehensive. It only looks after the needy and the indigent, and does not look after the tremendous two-thirds who have to be helped, not with money out of the Federal Treasury to pay for normal medical care, but given an opportunity to pay into an insurance fund.

Nor do I interpret those two paragraphs you have quoted in the way you do, though I want to say this: First, I never really studied the details of the bills carefully because I felt whenever a bill was going to finally be drafted it would be a compromise in detail, and done over, and I so state here, with respect to any final compromise you may arrive at.

Senator DONNELL. I understand.

Mr. LASKER. Don't you see?

Senator DONNELL. Yes.

Mr. LASKER. Consequently, I don't take them as a finished product.

Senator DONNELL. But if you will take those sections that I quoted.

Mr. LASKER. Will you give me those pages again?

Senator DONNELL. Pages 6 and 7.

Mr. LASKER. I didn't go through S. 1320 with a fine-tooth comb, but it undoubtedly is no perfect bill that should finally be passed by the Congress of the United States. I took it that there would be a lot of changes and I took it that these hearings are being conducted on the principle that there would be many changes. I took it that I was a witness on the principle, and I disqualified myself on the details.

Senator DONNELL. Now, the earlier portion to which I referred was pages 6 and 7, and page 9, beginning at the bottom of page 6.

unning

s 8 and

xt one,

direct
ined to

consul-
on desig-
in any

ords, in

Senator DONNELL. If you will let me finish, please, I may say in all fairness I am not so clear myself as to the meaning of this next sentence on page 7. It says:

> Whenever the Board, after consultation with the Advisory Council, finds that moneys in the account (established by section 271) are adequate and that facilities are available, it may by regulation increase the maximum days of hospitalization in any benefit year.

Mr. LASKER. Yes.

Senator DONNELL. Now, whether that is to limit it by these maxima up here, I would judge it will not. I would judge they would go further. That would be my opinion.

Mr. LASKER. I was going to ask you, would you read the other lines? I took it that there were reasons why it was that way, whether I agreed with it or not. You understand you cannot come into a full flowering in this kind of a venture the first day, the first month, the first year, or even the second year. There will be a lot of people paying into this fund who won't be able to get preventive medicine for a while. That is going to be a big obstacle.

Senator DONNELL. The time lag?

Mr. LASKER. The time lag, yes; and it was a detail that I did not bother to get myself informed about, though an important detail, I admit.

Senator MURRAY. At that point, Mr. Chairman, I would like to call attention to the fact that these provisions on pages 6 and 7 follow exactly the procedure that is followed in the overwhelming majority of hospitals in this country. A lay board decides which of the many suggested services are essential to good hospital care. American hospitals are considered the finest in the world, and we are following the practice that is followed in American hospitals.

Mr. LASKER. I took it that the heart of the matter was expressed from line 12, after the word "psychosis," and down to line 16, those lines inclusive.

Senator DONNELL. I would respectfully suggest, however, for your consideration, Mr. Lasker, the fact that the general rule apparently is laid down earlier, namely, that the maxima prescribed are 60 days and 30 days, and it is only when the Board, after consultation with the Advisory Council, finds that moneys in the account are adequate and facilities are available that there is any power to increase those maxima, In other words, you start out with the rule of 60 days, 30 days.

Mr. LASKER. Perhaps I ought to tell you what I took that to be.

Senator DONNELL. Yes.

Mr. LASKER. In the end it isn't always the length of the step that counts, but the direction. Do you gentlemen follow me?

Senator DONNELL. Yes.

Mr. LASKER. Now, my difficulty with S. 545 is not that it doesn't start at the right road, but it stops at the home of the indigent and does not proceed further on the road to the homes of the great working middle classes. We can't traverse the whole road immediately. Now, as to S. 1320, I took it that it was really a case of playing for time until there would be enough money in the general pool to permit of wider hospitalization, because hospitalization is where you run up into the great big money in medicine, and if that is not the purpose then it should be clarified to state what is the purpose.

ute. I
to this
s asked
italiza-
tuber-
here is
ospital
pointed
he Ad-
o allow
cancer

the bill
e fund,
to give
ne way

page 68
States,
nd the
in ade-
ces for

missioned officers and other personnel of the service detailed to assist in carrying out the purposes of this section with respect to cancer, and to administer this section with respect to such disease, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1948, and for each fiscal year thereafter, the sum of $10,000,000.

Now, that is a desirable thing, yet if you will compare the two bills and what they do with respect to either the preventive stage or the diagnostic stage, you will find, I think, that the general over-all scheme as set out in S. 1320 is far more adequate.

Mr. LASKER. I took it that the general over-all plan of S. 1320 was this: To start a pool that would have money in it to insure that the people could have the services of physicians of their selection, and at the same time let the physicians have patients of their selection, and that then it was left largely to the development of how much money would be left in the pool as to how much further it could go in the way of hospitalization.

Senator PEPPER. And then it attempts to make specific provision for the chronic case.

Mr. LASKER. Of course, I believe in the course of a few years, Senator Donnell——

Senator DONNELL. Yes?

Mr. LASKER. That if we have national health insurance, in the course of not so many years we will find we need much less hospitalization than we need now.

Senator DONNELL. You feel that after a while we will need much less hospitalization?

Mr. LASKER. I am committed to that deeply. This is what I believe. I believe that on a 10-year operation of this bill the net to the country would be a money profit. That is my belief.

Senator DONNELL. I see.

Mr. LASKER. And that the doctors by and large would be better off financially.

Senator DONNELL. Mr. Lasker, might I make this observation at this point? I referred a little while ago to page 68, to which attention was directed by Senator Pepper, as being a portion of S. 1320 which follows the theory of S. 545 of grants to States. I think that is correct. I made a further observation to the effect that it was the theory of title III, pages 69 and following, to follow along the line of the provision of these services for the needy. I am not sure whether I am correct on that, and I want to make my statement subject to this correction, that I would like to study that portion of the bill further to determine whether I am correct in that statement.

Senator PEPPER. There is no means test, even under the title III part.

Mr. LASKER. Oh, no. In my testimony I so stated, that in S. 1320 there is no means test. And again to quote from myself, as well as I remember, there are no police to come around and pry into the private affairs of a citizen, or humiliate him.

Senator DONNELL. I think you are in error, however, if I might respectfully say so, in your statement that there is no provision for a means test or anything. I take it by that you mean there is nothing of that sort in S. 1320.

Mr. LASKER. That is right.

Senator DONNELL. At page 13, S. 1320 has the heading "Provision of benefits for noninsured needy and other individuals."

out if a
o enable

neant?

u under-
t to it—
sclaimed
see? In
ertheless
n expert
espect to
If, then,
arge and
ow. Do

e way it
l have to
e marked
e people
was the
erica we
know or

Senator Donnell. I do not want to ask you about these things which you claim to be no expert on. However, you did give the cancer case as an illustration this morning, a case taken right from your own house, and you have come advocating a specific bill very eloquently and very powerfully, S. 1320.

Mr. Lasker. Oh, not as eloquently or powerfully as I should like to have done.

Senator Donnell. Let me complete this statement now, please.

Mr. Lasker. Yes, sir. I'm sorry.

Senator Donnell. I think it was perfectly proper, and I know you are not criticizing us for doing so, for us to ask you, in view of your observations about the cancer matter, what you had to say in regard to these limitations of hospitalization under S. 1320.

Now, may I say this further—this is not a question, but for the record—that we already have in the Public Health Service, grants and services to States which cover venereal disease authorization, and I quote from the statute, "to be appropriated for each fiscal year a sum sufficient to carry out the purpose of this subsection," and that subsection relates to the developing of more effective measures for the prevention, treatment, and control of individuals, and so on.

We likewise have in the same act, the Public Health Service Act, at 314 (b), a provision of like nature with respect to tuberculosis, and an authority for the appropriation of a sum for each fiscal year of 1945 sufficient to carry out the purposes of the subsection.

I want the record to show likewise that S. 545, at pages 12 and 13, contains a proposal to amend the Public Health Service Act by adding a new subsection, which is of a similar nature and is related, I think, to the venereal disease and tuberculosis sections of S. 1320. This amendment, contemplated and provided for in S. 545, relates to the control of cancer and provides likewise for an appropriation for the fiscal year ending June 30, 1948, and for each fiscal year thereafter, the sum of $10,000,000 for that general purpose.

Now, Mr. Lasker, I want to say that I am almost finished with examining you, and yet we happen to have a statute at present in effect, or a rule in effect under statutory authority, requiring this committee not to sit when the buzzer buzzes without leave of the Senate, and therefore it is our custom when that buzzer buzzes to recess for a very few minutes pending the obtaining of that consent, so I am going to ask your indulgence, please, when the buzzer buzzes for a few minutes, and then I will not detain you any further.

Mr. Lasker. If I may be permitted to do so, I should like to catch a 1 o'clock train. I had no notion when I started that I would be talking so long. I thought I would be here about 20 minutes.

Senator Donnell. The committee will be in recess for a few minutes.

Mr. Lasker. Thank you.

(A short recess was taken.)

Senator Donnell. Mr. Lasker, we may resume now, if that is agreeable to you.

Mr. Lasker. Yes, sir.

Senator Donnell. I had called your attention to certain language on page 7, and in the course of that language reference was made to the National Health Insurance Board. I am referring now to S. 1320.

Mr. Lasker. Yes, sir.

Are you
ce Board,

efresh my

ugh with

my state-

the func-

respect to
s bill?
ill.
f the Na-
1320?

. 1320.

nal Health

y so little

I had time, and you wanted it, I could make a deep study of it, but I have not yet done so. I read it through only casually because I really did not think it was going to be passed this year, you see. I didn't feel we were up to that yet. I just thought that there are hearings every year, from the sum total of which nothing happens for a long time and then the bill finally passes.

Senator DONNELL. Now, Mr. Lasker——

Mr. LASKER. Although, of course, I would like to see it pass this year. I wish it had passed last year, or the year before.

Senator DONNELL. I would like to ask you this. You are a businessman. You have had wide experience. And this matter which is set forth in S. 1320, which bill you have read, involves a matter of great consequence and large expenditures of money. Do you regard it of importance that there be a National Health Insurance Board?

Mr. LASKER. Well, there has to be some administrative board. For instance, the people of the United States have a board which is called the Congress of the United States. There must be administrators for everything.

Senator DONNELL. There must be administrators.

Mr. LASKER. Yes.

Senator DONNELL. Do you have any feeling about that board having some functions and ultimate powers vested in it? Do you favor that idea?

Mr. LASKER. Yes; but I do not want to get into details on the general principle of all these kinds of things. I like to provide for lay representation.

Senator DONNELL. Yes; but that isn't what I was getting at. I wanted to find out whether you think it is of importance to have an administrative board to which you refer, with ultimate powers and functions vested by the bill providing for this plan.

Mr. LASKER. Well, some board, someone.

Senator DONNELL. All right; that leads up to what I want to get at. If you will pay special notice for just a moment to line 22 at the bottom of page 38, and going over to page 39, you will observe this language:

> All functions of the Board—

that is this board we have been talking about—

> shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

I want to pause at this point and ask you if in any of the business enterprises with which you have been connected the functions, all functions, of the board of directors of the company shall be administered under the direction of the president or any other official of the company under his direction?

Mr. LASKER. I don't get it.

Senator DONNELL. Well, here is what I mean. Take Lord and Thomas, or any other firm or corporation.

Mr. LASKER. Yes.

Senator DONNELL. There is a board of directors of six to nine men, we'll say.

Mr. LASKER. Yes.

Senator DONNELL. And it has a president.

Mr. LASKER. Yes.

e board

on with
ng was

, would
a com-
hat, do

thought
get into
hat you

S. 1320?

appear

of page
nistered
Federal

rd shall
ervision

Mr. LASKER. No.

Senator DONNELL. And subordinate to the direction of the president?

Mr. LASKER. Not in business affairs, but that is the best you can get in Government. I was the chairman of the Shipping Board, and I would have been a dead hen if they had not been under my direction and supervision. I could not have gotten anywhere because then comes in political pull, which you don't run into in business, and men from the Hill, associations, and all that, and goodness knows that each one is the representative of a certain district, and there finally has to be some head. You see, for instance, I'll take the Shipping Board when I was there. I could not do anything in principle without a vote of the members of the Board, and I had only one vote the same as the rest, but the minute they voted on anything it was under my direction and supervision.

Senator DONNELL. But that is not what this bill says. This bill says that all functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

Mr. LASKER. Then some of that wording would have to be very carefully studied. It would have to be gone over with a fine-tooth comb.

I would like to make clear for the record what I think, that if there was an independent board with a chairman, the board votes as a board, but then the board also—I know this to be a fact in many corporations, I know many corporations where it is that way—where the board consists of people who spend their whole time in the corporation, and then after the board meets and determines things these people become department heads. From that point on the president administers, directs, and supervises the work of everyone.

Senator DONNELL. Now, Mr. Lasker, may I ask you this?

Mr. LASKER. But I can see how this wording is ambiguous. You are right.

Senator PEPPER. Before you get away from that, I have a question.

Mr. LASKER. I think it is ambiguous.

Senator DONNELL. Senator Pepper has a question.

Senator PEPPER. I think Dr. Parran also testified in response to the inquiry from the Senator from Missouri on the same point, and he said if the language was construed to mean what the Senator from Missouri indicated it to mean, merely that the Federal Security Administrator could overrule the Board on everything, that he would thoroughly agree with you that it needs interpretation, but he interpreted the language to mean that in other sections there the Board was given the authority to lay down the rules.

Mr. LASKER. I definitely agree that it does need clarification.

Senator PEPPER. You feel it is desirable to clarify that?

Mr. LASKER. Oh, yes; it needs considerable clarification.

Senator DONNELL. I appreciate the fact that time is flying, and I will try to get through with you as quickly as possible.

Mr. LASKER. I can take the 2 o'clock train in case I can't leave by 1.

Senator DONNELL. We will be through with you in a very few minutes now.

Mr. LASKER. I just feel that I am getting to the stage where I am beginning to bore you because I have been talking so much.

t want

if it is

row, all

ners.
to give

cluding
report
this is
patients
tients.”
ult that
se their

studied
20, par-
nsation
to the

1320.

take care of 500 persons. Let's call him Dr. Smith. Five hundred people go on his practitioner's list. Dr. Jones can also have 500 persons, and Dr. Williams can have 500. All right. Suppose Dr. Smith is generally considered to be the best doctor in Sedalia. I hope there isn't a Dr. Smith there, or I will be in trouble with the other doctors. But suppose he is generally considered to be the best doctor in Sedalia, and the people flock to the appropriate place to register in order to get on his list. Five hundred people come there in a hurry within the first few days and get on his list after this bill goes into effect. Then you and I, and Senator Pepper, and Senator Murray—we would like to have you come too—jointly go down and want to get on his list, but his list is already filled. Is there not there a limitation on the right of the patient to choose his doctor?

Mr. LASKER. No.

Senator DONNELL. Why not?

Mr. LASKER. No more than there is now. I have had the experience myself of wanting to get a doctor who is a specialist in something and he simply said to me, "I can't take you. I already have too many patients. I have too much to do as it is." And that is true right now, under our present system. Then he said, "However, I will give you the names of four men who are as good as I am." You know how I felt at that suggestion, don't you? I became angry and said, "You can turn me down if you want to, but don't try to tell me who is as good for me in your mind as I think you are." Now, if you can talk the doctor into taking you on in spite of everything, that's all right, but right today there are some doctors who cannot take on additional cases.

Senator DONNELL. Today, however, it is a matter for the determination on the part of the doctor and the patient together; if they can agree that he is going to take the case, and if he can take it, he will.

Mr. LASKER. It is a matter of determination on the part of the doctor and the patient as to whether or not he is going to take the case.

Senator DONNELL. I do not agree with you on this per capita basis where Dr. Smith has 500 patients on his list. As I understand it, that is the maximum number.

Mr. LASKER. Yes.

Senator DONNELL. In fact, there is some provision for that somewhere.

Mr. LASKER. But Dr. Smith can say that there are such-and-such names on the list that he doesn't want, so he has likewise had a right to choose his patients. Now I am in Sedalia; is that correct? I am back in Sedalia?

Senator DONNELL. Yes.

Mr. LASKER. My name is on Dr. Smith's list. I can say that I don't want to be on his list. Then they have to put me on another list.

Senator DONNELL. But, Mr. Lasker, suppose you want to get on the list and his list is full, you would agree that under this language there is no way for you to get on it. That is true; is it not?

Mr. LASKER. Well, of course; but that isn't that he has not had free choice and the doctor has had the freedom to say "no." Now, we don't want to have a police state of things. If we send him to the

aybe the
n, and in
ould not

natter, in
500, and
, on page

ices, shall
and shall
after con-

st of that

nits varied

who we
a—when
nat is his
n his list,
this bill,
Lasker?

Senator Donnell. I understand that, but in the case I have cited, Mr. Lasker, from the illustration I have given I think it is clear that when a doctor has his list full, and it is prescribed that that is his maximum, as is provided here under this language I have read to you, he cannot take any more. That is what "maximum" means; is that not right?

Mr. Lasker. Let me say it another way.

Senator Donnell. Is that not true?

Mr. Lasker. No.

Senator Donnell. My statement is not true, Mr. Lasker?

Mr. Lasker. Well, no.

Senator Donnell. Regardless of the interpretations.

Mr. Lasker. No; I don't like the inference of your statement.

Senator Donnell. I have not put any inference on anything.

Mr. Lasker. Your statement is an inference.

Senator Donnell. If there is a list of 500 persons, and it is filled, and then 10 more people come and want to get on that line, if the regulation says that 500 is all the doctor can take, 500 is the maximum, then those 10 men cannot get on that doctor's list. Is that true or not?

Mr. Lasker. I am talking about——

Senator Donnell. Won't you please answer that question?

Mr. Lasker. No; I won't answer yes or not. That's like asking me to answer "yes" or "no" to the old question, "have you quit beating your wife?"

Senator Donnell. No; it is not.

Mr. Lasker. Senator, I can see your viewpoint, and I can see that it is honestly fixed in your mind that way, and I am going to try to show you that it isn't that way.

Senator Donnell. All right; go ahead.

Mr. Lasker. I see that it is honestly fixed in your mind. I think I can give you an illustration. In New York we have what is called the Blue Cross plan. You know, of course, all about the work of that organization.

Senator Donnell. Well, not all about it.

Mr. Lasker. Now, I know of not only 1 or 10 or scores, but I know of hundreds of cases of people who have paid in advance for hospitalization under the Blue Cross insurance plan. Their doctor has certified that they should go into the hospital, and they have had to wait from 2 to 3 weeks or more before they could get in, and in some cases they couldn't even get into the hospital of their choice. The hospital simply was filled up. Now, that is happening in every city in America today under the Blue Cross plan, which is perhaps the largest and most successful medical-aid plan that we have today. Now, I think we can have a meeting of minds if I answer your question by giving the analogy of the Blue Cross plan.

Senator Donnell. Mr. Lasker, I don't think you have answered my question. You have talked about a presently existing medical-aid plan. I am not going to ask you any more except this once.

Mr. Lasker. I am not trying to be fractious. I just don't want to testify to something that I don't see.

h I think
ised, Dr.

t list has

and say,
umber on
e regula-
ly follow

umber of

question.

500.

ion about
here is a

Senator MURRAY. You have asked him.

Senator DONNELL. I know I have, and I would like to get a statement on it. That is one question on which I haven't been able to get an answer from him.

Now, Mr. Lasker, the list consists of 500 people. There it is—a list with the names of 500 people on it, right there in front of us. You also have a regulation under S. 1320 that 500 is all he can take. Ten more people come along and want to get on that doctor's list, but it is already filled up. Those 10 other people cannot get on that doctor's list, can they?

Mr. LASKER. I don't know about that 500. I think that is dangerous—that is dangerous medicine.

Senator DONNELL. You are not answering my question.

Mr. LASKER. I don't see how he is going to be able to look after 500 all at one time.

Senator DONNELL. All right. Make it 200 then. If the doctor has a list of 200, and the regulation says that 200 is all that Dr. Smith can take, but 10 more people want to get him to take care of them, they cannot get on his list; can they?

Mr. LASKER. If a doctor——

Senator DONNELL. They can't; can they?

Mr. LASKER. If a doctor has all the patients he can handle today under the present set-up, they can't get on his list.

Senator DONNELL. I am talking about the lists under the bill. If the list is already filled with 200 names, and the regulation says 200 is all he can take, and then 10 more come along and want to get on his list, can those 10 get on? What is your answer on that, "yes" or "no"?

Mr. LASKER. My answer would be that I don't know the bill well enough to answer "yes" or "no." But I have such faith in the American people that when it comes to be worked out it will be worked out as nearly practicable as human beings can do it.

Senator DONNELL. You still have not answered the question, Mr. Lasker.

Mr. LASKER. I have been disturbed about that. I have tried to answer all your questions, if I understood them.

Senator DONNELL. I think you could also answer that question, Mr. Lasker. When it comes right down to plain numbers, 510 is more than 500; isn't it? We do agree to that; do we not?

Mr. LASKER. What?

Senator DONNELL. We agree that 510 is more than 500? You do agree to that, don't you?

Mr. LASKER. Yes.

Senator DONNELL. And 210 is more than 200, you would agree to that?

Mr. LASKER. Yes. But don't ask me anything about algebra. I told you I only went to high school.

Senator MURRAY. Mr. Lasker, isn't it a fact that in the large cities of this country and in many of the medium-sized cities of this country people are not always able to get the doctor of their choice when they want him?

le travel
rgeon at
hen they

ake.
very in-
hat they

back to
k me by
wer you

doctors

e or not.
t?

original
between

t longer.
it today,

Senator DONNELL. Well, you said in your statement, "I was on the opposite side of the fence on that pure-food bill."

Mr. LASKER. That's right. But I did not do anything about it. I did nothing.

Senator DONNELL. But your judgment at that time was that it was a mistake and you were opposed to it; is that correct?

Mr. LASKER. Well, I guess that parts of it looked as if they would affect my interests. I was opposed to them.

Senator DONNELL. The question is, You were opposed to the bill?

Mr. LASKER. That's right.

Senator MURRAY. Was your position the same with respect to the stock brokers in New York?

Mr. LASKER. The point I make is that anyone with a vested interest cannot be objective, and my plea here is that I'm human too.

Senator MURRAY. So the security dealers of the country were very bitterly opposed to the Securities and Exchange Commission when it was first proposed, and now they wouldn't think of having the act that set the Securities and Exchange Commission up repealed, because it is protecting them.

Mr. LASKER. I wrote the sentence about those other bills in my prepared statement because I did not want to seem to criticize any doctors who were opposing this, because I do not criticize them. They are still among the noblest and most self-sacrificing of our people. They practice a priesthood that means much to all of us. I merely believe we can and must help them to multiply their help to us. That is all.

Senator MURRAY. Mr. Lasker, you say that you would like to see a broad public discussion of the problems involved in these bills.

Mr. LASKER. Yes.

Senator MURRAY. Are you familiar with the National Physicians' Committee, which has carried on propaganda against this measure?

Mr. LASKER. Yes; and I want to say that I have also heard that that committee, which is carrying on political propaganda, is tax deductible.

Senator MURRAY. Yes.

Mr. LASKER. Whereas the National Health Committee, to which I plead guilty of contributing, is not tax deductible, and I would like at this hearing to bring out why is not a lay movement entitled to the same privileges as a department of the American Medical Association.

Senator MURRAY. Of course, in reality the deductions of contributions to the National Physicians Committee are not deductible.

Mr. LASKER. I understood they were.

Senator MURRAY. But the management of that organization induced people to contribute to them on the basis that they could make deductions of those contributions, and I believe that doctors all over the country and other people who have contributed to that committee, have wrongfully made those deductions which they should not have made. I believe the committee should have been prosecuted for its misleading advertisement, and for its action in inducing people to violate the law by making contributions and then deducting them from their income-tax reports.

thought

als who
to do it,
ey have

ate from

e thing.
ons and

a broad

of some
manner

give you
playing
ln't like.
th great

' can be

Senator DONNELL. They will be incorporated into the record, and I shall also offer, with your approval, for the record, a release by the Committee for the Nation's Health, Inc., for release Thursday, July 10, 1947, referring to the charges made by Mr. Thurman Arnold, being an exhibit to which I referred earlier in the testimony today.

Senator PEPPER. No objection.

Senator MURRAY. No objection.

(The document referred to follows:)

[For release Thursday, July 10, 1947]

THURMAN ARNOLD CHARGES AMA WITH MONOPOLISTIC PRACTICES

COMMITTEE FOR THE NATION'S HEALTH, INC.,
Washington 1, D. C.

Charging that medical societies "have assumed power over the practice of the profession, licensed by the State, and over the civil rights of American citizens," Thurman Arnold, former Assistant Attorney General, launched an attack on the Taft health bill.

Specifically referring to the health bill now sponsored by Senators Taft, Ball, Smith, and Donnell, the former trust buster declared that in his opinion "this bill would substantially increase the powers and monopolistic control of organized medicine."

He charged that the Taft bill would give "substantial control over the policies for expending Federal funds to officials who would be the creatures of organized medicine. * * *" He told the Committee for the Nation's Health, which is supporting the national-health insurance bill, S. 1320, that in his opinion the Taft bill would increase the "* * * monopolistic powers and tendencies now exercised by these State societies."

Arnold had been asked by the Committee for the Nation's Health for an opinion on the monopolistic implications, if any, of the Taft bill. The full text of the Arnold letter is attached.

(The Committee for the Nation's Health will testify before the Health Subcommittee of the Senate Committee on Labor and Public Welfare on July 10. Spokesmen will be Joseph Louchheim, executive director, and Dr. Michael Davis, chairman of the executive committee.)

Senator MURRAY. Senator Pepper and I have stated our own positions on the basic principles involved in S. 545 and S. 1320 during last year's hearings on S. 1606 and during the hearings before this subcommittee. It is not necessary to repeat them at this point.

We do ask, however, that report No. 5 of the Subcommittee on Health and Education to the Committee on Education and Labor, dated July 1946, be placed in the record of these hearings along with the statements of the cosponsors of S. 1320.

Senator Pepper and I believe it to be the most complete, concise, and accurate presentation of the need for national health insurance and of the inadequacies of current attempts to solve the problem before us.

(The document referred to and the statement of Senators Wagner, McGrath, Taylor, and Chavez follow in succession:)

R FROM

eport of

y 1945,
s health
ad unfit
ch were

e some
at least
sickness

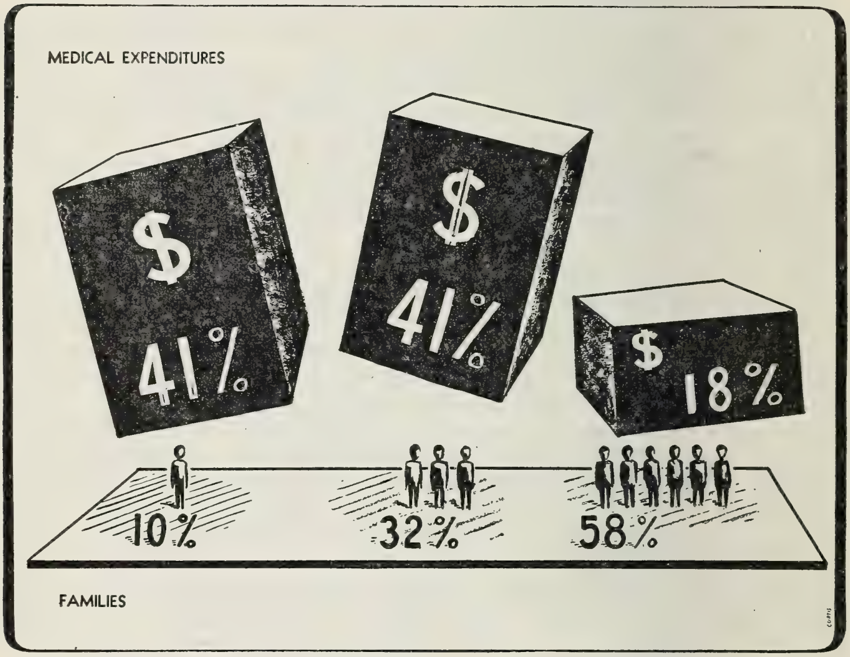
sanitation, public health, medical research, education, and medical care for the needy.

The report also expressed dissatisfaction with the prevailing "pay as you go" or fee-for-service method of payment for medical services but withheld judgment with regard to the claims that voluntary health insurance plans offer a satisfactory solution to the problem. This report summarizes the results of our further study of this subject and sets forth the conclusion we have reached.

THE COSTS OF MEDICAL CARE

The burdens of sickness and of medical care fall unevenly on the people. Illness strikes some families hard, while others may not be touched. In any year, 47 percent of the people will have no serious illness at all, 51 percent will be sick one to three times, and 2 percent four or more times. The next year, some new families will be hit, while some of the same families will continue to suffer. The costs of medical care are also subject to wide variation. In any year, a tenth of the population has to bear four-tenths of the total burden of medical expenditures (fig. 1).

FIGURE 1. THE COSTS OF MEDICAL CARE ARE UNEVENLY DISTRIBUTED



Source: Committee on the Costs of Medical Care.

When sickness does hit hard, wage losses and medical costs may wipe out a family's entire savings and drive it into debt. Material in our files indicates that people borrow from small loan companies to meet medical expenses more frequently than for any other single reason. Illness is also the most frequent cause leading people to seek ng-con-

costly.
rcent of
ata are
atistics
amilies
at less.
ess and
income
ncomes
ive less

SS CARE

Charity does not begin to take care of the need. Decent charity care is usually not available in small towns and rural areas, and even in large cities it is far from satisfactory. Table 1 shows that only a small percentage of those in the very lowest income group in rural areas get any free medical care, though many undoubtedly need it.

TABLE 1.—*Percentage of families reporting any free medical care received, 1941*

Net family money income	Place of residence		
	Rural farm	Rural nonfarm	Urban
0 to $449	6.9	13.9	17.3
$500 to $999	8.8	12.4	22.9
$1,000 to $1,499	3.6	14.0	11.1
$1,500 to $1,999	4.9	6.8	11.6
$2,000 to $2,999	6.2	5.8	9.3
Over $3,000	4.9	6.2	8.8
All incomes	6.4	11.2	12.5
Number of families answering	762	981	1,300

NOTE.—Adapted from data collected by Bureau of Human Nutrition and Home Economics and Bureau of Labor Statistics. Represents percentage of families stating that any family member had received free physician, hospital, clinic, dental, nursing, or eye care, drugs, or medical appliances, in the course of the year. For details of study, see U. S. Department of Agriculture, Miscellaneous Publication No. 520, June 1943.

While it is true that many doctors give their services free, no physician can estimate the number of people who do not come to him when they are in need. Except in emergencies, and sometimes even then, most people would rather do without care than "lower themselves" to ask for charity.

That there are actually a good many disabling illnesses for which no medical care is received and that these instances are most frequent in the lower income groups is shown by the following table:

TABLE 2.—*Percentage of disabling illnesses lasting a week or longer for which no doctor care was received*

Income group	Percentage of illnesses without doctor care
Under $1,000	22
$1,000 to $2,000	18
$2,000 to $3,000	15
$3,000 to $5,000	13
$5,000 and over	11
All incomes	19

Source: National Health Survey data, 1935.

It was on the basis of facts such as these that the subcommittee voiced the opinion in its Interim Report No. 3 that the current "pay as you go" or fee-for-service system must be replaced by "some form of group financing which would make it possible to share the risks and distribute the costs more evenly."

ed years
re costs.
ing, and
d spread
shments.
s during
izations
rotected,

hospital bill covered, i. e., bed, board, nursing, operating room, laboratory fees, etc., while in the hospital. (See table 3 and fig. 4.) Relatively few people had any coverage of dental, home nursing, or preventive care costs, or regular health examinations. The figures may involve a good deal of overlap.

TABLE 3.—*Number of people known to be covered by voluntary health insurance, 1945*

Types of coverage	Number (in millions)	Percent of population (1945) [1]
Comprehensive medical care [2]	3.5	2.5
Partial physician or surgeon service (most with hospitalization)	14.0	10.0
Hospital care only	17.5	12.5
Any item covered (physician, surgeon, general hospital, or dentist)	35.0	25.0
No prepaid medical care	105.0	75.0

[1] U. S. Census Bureau estimate, 140,000,000.

[2] "Comprehensive" is used to mean at least relatively full physician's and surgeon's care in office, home, and hospital and general hospital care.

Principal sources: United States Chamber of Commerce Health Insurance Conference Proceedings, January 1945; Klem, Margaret, Prepayment Medical Care Organizations, Social Security Board Memorandum No. 55, June 1945; the Journal of the American Medical Association, vol. 128, p. 1173, 1945; Blue Cross Bulletin, vol. 8, No. 5, May 1945; letters to subcommittee from medical care insurance experts.

The 25 percent of the population with some kind of coverage subscribed to three main types of plans: Nonprofit hospitalization (Blue Cross), prepayment medical care organizations (sponsored by industry, medical societies, consumer organizations, private physicians' groups, or Government), and commercial health and accident insurance plans. (See fig. 5.)

WHAT THEY GET

More detailed data are available for the approximately 5,000,000 members of various kinds of prepayment medical care organizations. Table 4 indicates that the type of medical service offered varies considerably with the different types of organization. In general, the medical-society-sponsored plans, excluding those in the States of Washington and Oregon,[2] tend to offer more restricted services. Government-sponsored, industrial, private group, and consumer-sponsored plans tend to be more comprehensive.

SERVICE AND CASH

Medical care insurance is of two types—service and indemnity. The service type assures stipulated kinds of medical care, such as physician's, surgeon's, or hospital service, to the patient. The indemnity type pays the subscriber specified amounts of cash toward expenses incurred during illness or accident—so much for a particular operation, hospital stay, or day of disabling illness. In the case of the indemnity type the practitioner or hospital may or may not charge more than the amount of the cash benefit, and the patient may or may not use the money to pay his medical bills. Although the

---

[2] These plans differ from other medical society plans in their historical origins and relationships with the American Medical Association. They are listed separately by both the Social Security Board and the American Medical Association.

IVED

indemnity type of insurance is common, it affords a less satisfactory type of protection from the health standpoint than do the service plans. It is not designed to guarantee medical service, especially for minor illness and prevention, but to fulfill certain economic functions. These are (1) replacement of wage loss, and (2) reimbursement for part or all of the expenses incurred during major disabling illnesses. The indemnity and service plans should be carefully differentiated; the latter is more accurately termed "medical care insurance" than the former.

TABLE 4.—*Number of persons eligible for care under prepayment medical-care organizations and percent eligible for specified services, by type of organization, 1945*

Type of organization	Number of persons eligible for care	Percentage distribution of persons eligible for physicians' services				Percent of persons eligible for—		
		Medical or surgical care in home, office, and in hospital	In home and office only	In hospital only		Hospitalization	Some type of dental service	Special-duty or visiting-nurse service, or both
				Medical and surgical cases	Surgical cases only			
Total	4,975,850	60.8	4.1	10.7	22.9	66.3	30.4	44.2
Industrial:								
Financed by employer	212,590	83.2	3.9	------	12.9	95.4	30.4	45.6
Financed jointly by employer and employee	546,772	92.1	6.7	.1	1.1	88.5	77.9	70.9
Financed by employee	752,786	84.8	2.0	1.0	2.5	97.4	44.3	76.7
Medical society:								
Washington and Oregon	954,100	100.0	------	------	------	100.0	29.1	84.6
Other States	1,640,256	7.0	------	26.7	66.3	13.3	------	------
Private group clinic	406,330	80.7	------	19.3	------	92.3	57.1	39.6
Consumer-sponsored								
Financed partly by Department of Agriculture	23,553	100.0	------	------	------	100.0	100.0	------
Other	326,561	52.4	44.1	3.2	.3	59.4	12.6	9.6
Governmental:								
War Food Administration and cooperating agencies	97,300	100.0	------	------	------	100.0	100.0	100.0
Other	15,602	100.0	------	------	------	100.0	100.0	1.2

Source: Adapted from data in Klem, Margaret, Prepayment Medical Care Organizations; Social Security Board, Bureau Memorandum No. 55, third edition, June 1945.

BLUE CROSS

The largest of all voluntary health insurance organizations is the Blue Cross system. By October 1945, 18,400,000 people were reported to be covered by this type of plan.

The Blue Cross plans are semiautonomous nonprofit hospital service plans approved by the American Hospital Association. They cover the expenses that are ordinarily included in the general hospital bill (bed, board, operating room, ordinary hospital drugs, and nursing service) for a specified period of hospitalized illness, usually for 21 to 30 days. Partial payment for 60 days additional is common. Enrollment is mainly by employed groups. The cost for a family of four is usually about $24 a year which may be partly or completely borne by the employer.

00,000
l their
l phy-
ntitled
(See

ospital
r other
t one-
geons'

The various types of medical care prepayment plans differ widely in the services they offer. (See fig. 7, pp. 14–15.)

GROUP PRACTICE PLANS

Most of the plans offering comprehensive prepaid medical care are group practice plans, sponsored by industrial firms, consumers, or physicians. In general, they offer services to groups of employed individuals and sometimes to their families. The doctors are usually on salary, full-time or part-time, and the service is given mainly in clinics rather than in the individual doctor's office or in the patient's home. The cost ranges from $12 to $36 a year per person and from $36 to $100 or more for a family of four. A typical cost is $24 a year per person.

Certain data concerning a few of these plans are shown in table 5.

TABLE 5.—*Examples of group practice prepayment medical care plans which provide comprehensive service*

Name plan	Number of people covered	Number of doctors		Number of registered nurses employed	Charges per year	
		Full time	Part time		Individual	Family of 4
1. Ross-Loos Medical Group, Los Angeles, Calif.	26,890	92	0	101	$30.00	(1)
2. Stanacola Employees Medical and Hospital Association, Baton Rouge, La.	19,200	8	3	1	[2] 36.00	[2] $36.00
3. Farmers' Union Hospital Association, Community Hospital, Elk City, Okla.	9,381	4	0	4	[3] 12.00	[3] 25.00
4. Group Health Association, Washington, D. C.	8,522	6	9	9	[4] 27.00	[4] 84.00
5. Trinity Hospital, Little Rock, Ark.	4,554	6	0	25	24.00	86.00
6. Endicott-Johnson Corp., Workers Medical and Relief Department, Johnson, N. Y.	42,000	12	15	30	[5] 48.00	[5] 99.00
7. Southern Permanente Foundation, Kaiser Co., Fontana Calif.	4,900	7	2	20	31.20	93.60

[1] Reduced fees for individual services to dependents; 73,000 dependents covered.
[2] Initial membership fee of $20. Special assessments up to $9 in any one year.
[3] Initial membership fee of $50. Extra charges; e. g., for home calls and hospitalization.
[4] Initial membership fee of $12. Certain extra charges.
[5] Company pays all. Figures refer to cost to company in 1941. Includes sickness disability payments of $12 per week for employee.

Principal source: Klem, Margaret, Prepayment Medical Care Organizations, Social Security Board Memorandum No. 55, third edition, June 1945; information as of 1945.

Forty percent of all members of prepayment medical care organizations obtain care through group practice. Over half of these, or 1.3 million people, are members of industrial type plans; the others are members of private group clinics or consumer sponsored plans.

In order to illustrate concretely what such plans offer, a summary description of one of the best-known plans is shown in table 6.

TABLE 6.—*Ross-Loos medical group* (*Los Angeles, Calif.*)—*Private group clinic*

COST

Individual: Group, $30 a year.
Nongroup, $36 a year.
Family: Reduced fees.

METHOD OF PRACTICE

Group, full time.

REQUIREMENTS

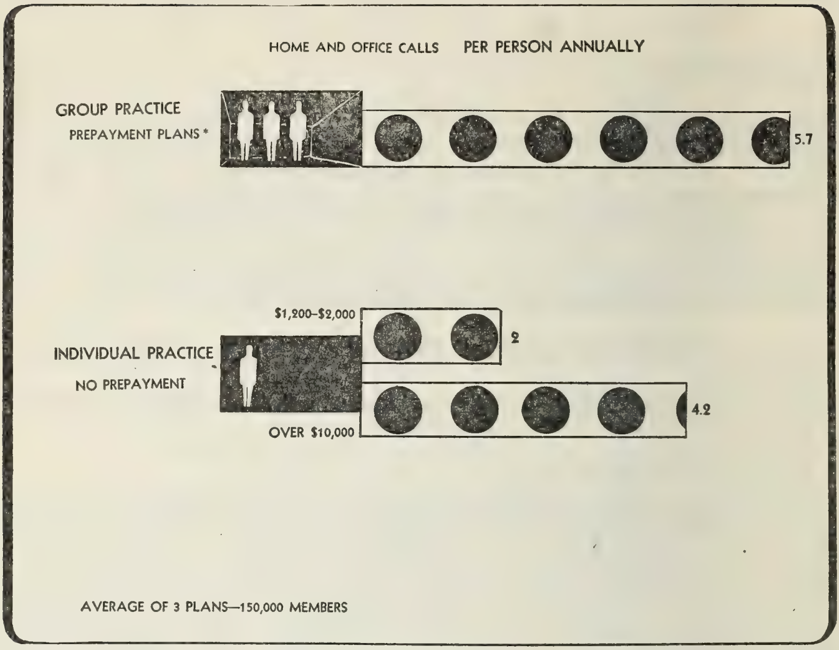
Age and physical examination requirements if not in group. (No income requirements.)

clinic—

orkmen's

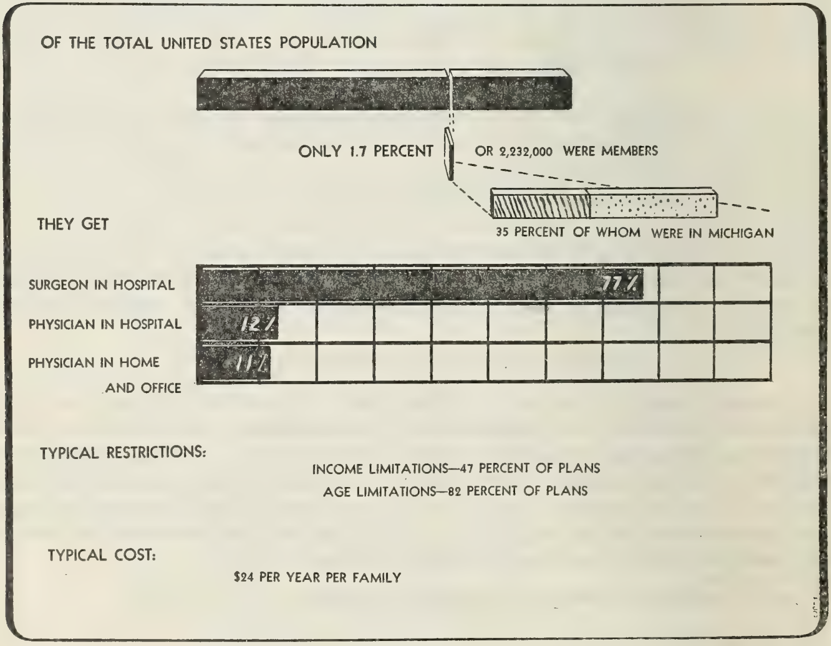
t plans
doctors,
medical
al Asso-
to enter
arity is

FIGURE 8. MEDICAL SERVICES RECEIVED



The three plans were selected because their membership (with their families) comprised more or less a cross section of an employed population. See The Experimental Health Plans of the United States Department of Agriculture, Subcommittee Monograph 1, January 1946, p. 33.

FIGURE 9. MEDICAL SOCIETY PLANS, 1945



Source: The Journal of the American Medical Association, vol. 124, p. 371, 1944; vol. 128, p. 1173, 1945.

a year.
lization.
may be
l illness

e shown
ent and

societies
ehensive
owever,
hy is it
to offer
y plans

rnishing
ty plans
ne have
On the
full- or
rganiza-
by two
nditions

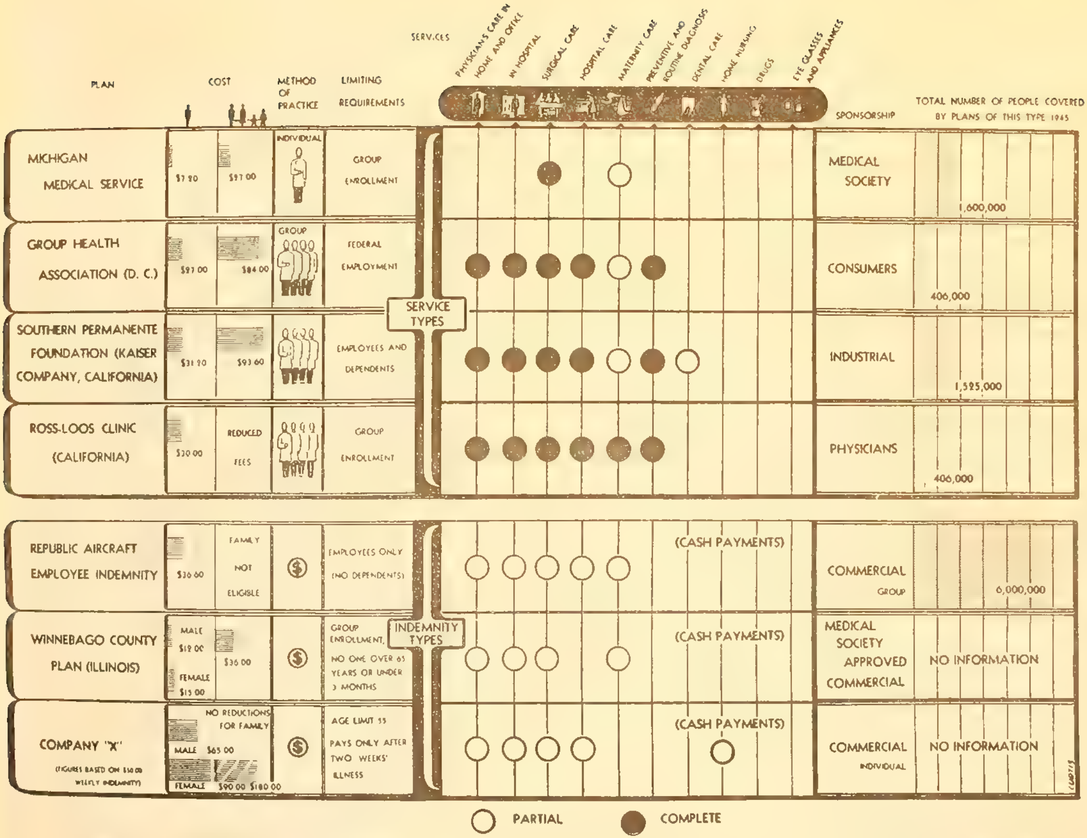
medical

TABLE 7.—*Examples of medical society plans—Descriptions in terms of family of 4*

Name	Year begun	Number of people covered (subscriber and dependents)	Requirements	Benefits	Cost to family of 4
Michigan Medical Service: Surgical benefit plan.	1940	777,104	Group enrollment only; minimum number, 10; minimum percent of total group, 75; extra charges if income is over $2,500 per year.	Surgery in office, home, and hospital; maternity care after 9 months' membership.	$27.00
California Physicians' Service: State-wide surgical plan.	1939	123,000	Group enrollment; children under 1 month and over 19 years excluded; additional charges if income is over $3,000 per year.	Surgical care; includes Caesarean sections and care for ectopic pregnancy.	36.00
Colorado Medical Service: Surgical plan.	1942	65,702	Group enrollment; children under 1 month and persons over 60 years not eligible. Additional charges if income is over $2,400 per year for family of 4.	Surgical care in home, office, hospital; maternity care after 1 year membership.	24.00
Delaware Medical Care Plan	1943	56,341	Group enrollment; children under 1 month and over 18 years not eligible; maternity benefit, $50; tonsillectomy after 1 year.	Surgery and 2 weeks aftercare up to $150 in any one illness.	19.80
Massachusetts Medical Service	1943	114,656	Group enrollment; dependent children over 19 or married excluded; additional charges if income over $2,500 a year.	Care for hospitalized illness; surgical benefits within specified limits; maternity care, 40 percent of cost after 9 months.	24.00

NOTE.—Information relates to middle of 1945. Source: Same as fig. 9.

ERED
S



SERVICE TYPES

PLAN	COST (individual)	COST (family)	METHOD OF PRACTICE	LIMITING REQUIREMENTS	PHYSICIANS CARE IN HOME AND OFFICE	IN HOSPITAL	SURGICAL CARE	HOSPITAL CARE	MATERNITY CARE	PREVENTIVE AND ROUTINE DIAGNOSIS	DENTAL CARE	HOME NURSING	DRUGS	EYE GLASSES AND APPLIANCES	SPONSORSHIP	TOTAL NUMBER OF PEOPLE COVERED BY PLANS OF THIS TYPE 1945
MICHIGAN MEDICAL SERVICE	$7.80	$27.00	INDIVIDUAL	GROUP ENROLLMENT			●		○						MEDICAL SOCIETY	1,600,000
GROUP HEALTH ASSOCIATION (D. C.)	$27.00	$84.00	GROUP	FEDERAL EMPLOYMENT	●	●	●	●	○	●					CONSUMERS	406,000
SOUTHERN PERMANENTE FOUNDATION (KAISER COMPANY, CALIFORNIA)	$31.90	$93.60		EMPLOYEES AND DEPENDENTS	●	●	●	●	○	●	○				INDUSTRIAL	1,525,000
ROSS-LOOS CLINIC (CALIFORNIA)	$30.00	REDUCED FEES		GROUP ENROLLMENT	●	●	●	●	●	●					PHYSICIANS	406,000

INDEMNITY TYPES

PLAN	COST (individual)	COST (family)	METHOD OF PRACTICE	LIMITING REQUIREMENTS	PHYSICIANS CARE IN HOME AND OFFICE	IN HOSPITAL	SURGICAL CARE	HOSPITAL CARE	MATERNITY CARE	PREVENTIVE AND ROUTINE DIAGNOSIS	DENTAL CARE	HOME NURSING	DRUGS	EYE GLASSES AND APPLIANCES	SPONSORSHIP	TOTAL NUMBER OF PEOPLE COVERED BY PLANS OF THIS TYPE 1945
REPUBLIC AIRCRAFT EMPLOYEE INDEMNITY	$36.60	FAMILY NOT ELIGIBLE	$	EMPLOYEES ONLY (NO DEPENDENTS)	○	○	○	○	○			(CASH PAYMENTS)			COMMERCIAL GROUP	6,000,000
WINNEBAGO COUNTY PLAN (ILLINOIS)	MALE $12.00 FEMALE $15.00	$36.00	$	GROUP ENROLLMENT, NO ONE OVER 65 YEARS OR UNDER 3 MONTHS	○	○	○		○			(CASH PAYMENTS)			MEDICAL SOCIETY APPROVED COMMERCIAL	NO INFORMATION
COMPANY "X" (FIGURES BASED ON $30.00 WEEKLY INDEMNITY)	MALE $65.00 FEMALE $90.00	NO REDUCTIONS FOR FAMILY $180.00	$	AGE LIMIT 55 PAYS ONLY AFTER TWO WEEKS' ILLNESS	○	○	○	○				(CASH PAYMENTS) ○			COMMERCIAL INDIVIDUAL	NO INFORMATION

○ PARTIAL ● COMPLETE

Source: In all cases, descriptive booklets issued by the plans themselves.

FIGURE 7

unts of
s. The
surance
percent
cent for
f cases,
nursing
causing
regular
ve high
Thus,
ess and
policy-
ccident
cal and

4 under

With dental care
$147
352

icago Press,

TABLE 9.—*Republic Aircraft Products group insurance plan (Travelers Insurance Co., Hartford, Conn.)*—Continued

NOT INCLUDED

1. Medical care other than as specified above.
2. Full hospital care other than as specified above.
3. Maternity care other than as specified above.
4. Dental care unless surgical.
5. Routine preventive and diagnostic procedures.
6. Drugs and appliances.
7. Home nursing.
8. Services ordinarily obtainable from governmental agencies.

Source; Company booklet.

Table 10 summarizes the provisions of a common type of individual sickness policy. No claim is made that this is "the" typical policy. Variations in policies of this kind are so great that it would be impossible to pick any one as typical.

TABLE 10.—*Individual health policy (specimen)—Commercial indemnity, individual type*

COST [1]

Individual:
    Men, $65 annually.
    Women, $90 to $180, depending on occupation.

TYPE OF PRACTICE

Immaterial. Patient pays bills as usual.

REQUIREMENTS

Benefits begin only after first 14 days of any period of disability.
Disability due to accidents excluded.

BENEFITS—CASH INDEMNITY

1. Total disability: $50 a week for up to 52 consecutive weeks in event of continuous complete disability, after waiting period of 2 weeks.
2. Hospital and/or nursing: $25 a week up to 20 weeks in event of hospitalization or necessary attention by graduate nurse.
3. Surgical. Up to $200 according to set fee schedule for operations.

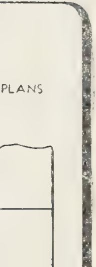
Services not indemnified (other than as specified above):
1. Physician.
2. Maternity.
3. Dental.
4. Routine preventive and diagnostic services.
5. Drugs and appliances.
6. Services provided by government.

[1] Depends on weekly indemnity. Rates given here are for $50 per week, a common type written. They are quoted by underwriters at multiples of $5 per weekly indemnity; those given above are for 10 times the base rate. Premiums given are for age group 18–49. Extra charges are made for age group 50–54, age 55 and over excluded.

SHORTCOMINGS OF VOLUNTARY MEDICAL-CARE INSURANCE

Voluntary medical care insurance plans have run into numerous difficulties, and many have failed. As has been shown, only a small part of the population has any form of medical care insurance. The number of people eligible for medical care in prepayment medical-care organizations increased from 3,300,000 in 1943 to 4,980,000 in 1945, but most of this increase was in plans covering only "catastrophic illness."

redomi-
n. The
percent
form of
fell off
early to
ng rural
hat the
tal care
ng rural
that is
ponsored



means that a person may choose not to join, even if he can afford to do so. Experience shows that a substantial segment of the population believes that, regardless of the plans' merits, they do not need them.

A poll in Rochester, N. Y., showed that the two main reasons given for not having hospital insurance were: "Can't afford it" and "Don't need it." (See fig. 11.) These results are especially significant, because Rochester has a much larger proportion of its population covered by hospital insurance than most cities.

The question of how much people can actually afford to pay for medical-care insurance is, of course, a complex one. It is well to point out, however, that even in the prosperous year 1942, one-half the families in the United States had incomes of less than $2,000. In that year such families spent an average of $58, or somewhat over five percent of their income, for medical care. If we assume that they cannot pay more, it becomes clear that most of them cannot afford membership in existing medical-care prepayment plans which provide anything like comprehensive service. Membership in the limited-benefit plans is also out of the question as far as most of these people are concerned.

Employer contributions to some prepayment medical-care plans do, of course, ease the burden on such families, but they are not always forthcoming.

Turn-over of membership in voluntary plans is another serious shortcoming. Even the Blue Cross plans, which minimize this factor through such techniques as group enrollment, have a 25-percent annual turn-over in membership. Other types of plans have even greater difficulty in maintaining a stable membership. It is not uncommon to hear a person say, "We didn't have sickness in our family last year, so why should we join again?" The result is that the healthiest members tend to drop out, while the ones who are most often sick tend to stay in. As this process continues, the plan is required to pay out an increasing proportion of its funds for medical services, and eventually it may find itself approaching insolvency. The only remedy then is to increase the charge to members or reduce the benefits to which they are entitled. This has been the experience of several of the plans sponsored by medical societies; for example, those in Michigan, California, and New Jersey.

This characteristic feature of voluntary plans is illustrated in striking, if extreme, fashion by a study of membership turn-over in a Government-sponsored voluntary plan for low-income farmers in rural Ohio. (See fig. 13.)

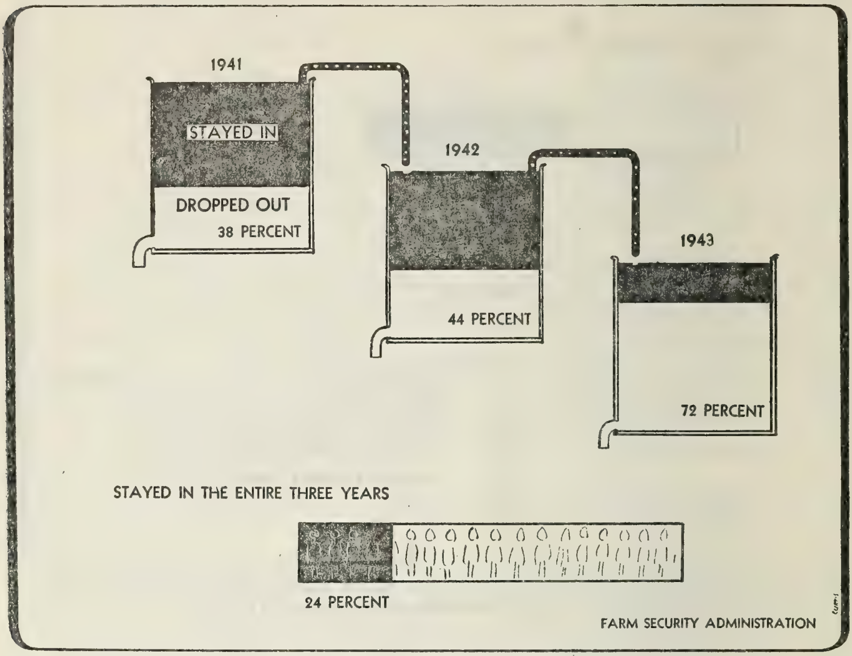
After 3 years of operation only 24 percent of the original membership still belonged to the plan. The families who remained used the plan most, while those families which used it least tended to drop out.

In the industrial plans, maintenance of membership is, of course, dependent upon continued employment. Even in normal or boom times this is a decided disadvantage, and in a period of depression protection is lost by a substantial proportion of the members at the very time when their need is greatest. In this connection it is interesting to consider the experience of the Permanente Foundation plans sponsored by the Kaiser Shipbuilding Co. on the west coast. At the peak of the war-production period, 76,000 of the 90,000 Kaiser employees belonged to one of the plans. By November 1945, however, when employment had fallen, only 7,500 shipyard members

ERCENT

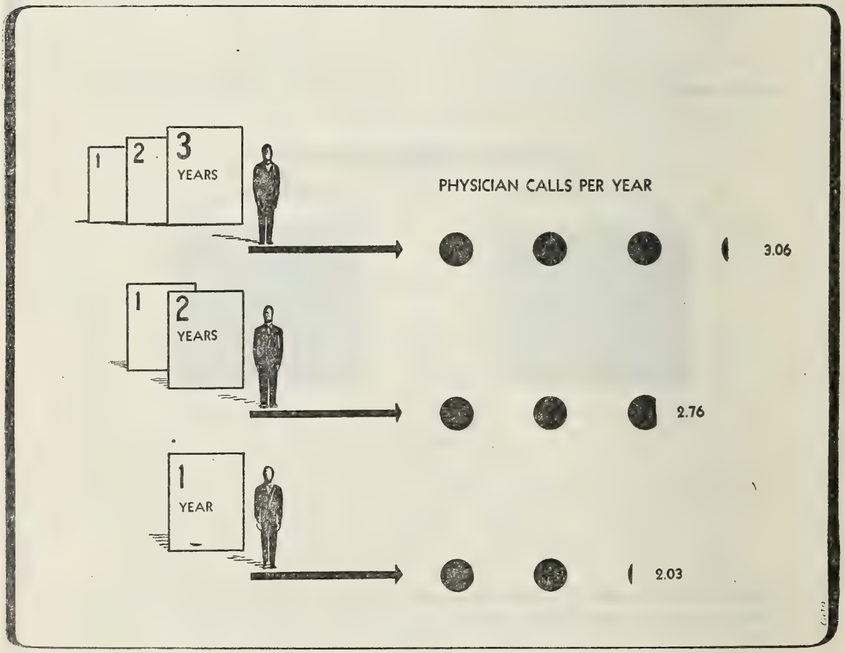
., conducted

Figure 13. Turn-over In a Voluntary Medical Care Plan, Rural Ohio



Source: McNamara, R. L., and Mangus, A. R., Prepayment Medical Care Plans for Low Income Farmers in Ohio. Agricultural Experiment Station, Worcester, Ohio, Bull. No. 653, October 1944, pp. 20–22.

Figure 14. Those Who Used the Plan Most Remained Members



Source: Same as fig. 13.

f "poor
ner rigid
usually
n," i. e.,
lan less.
eligible

se with
luntary
g those

prepay-
toward
he com-
migrant
resenta-

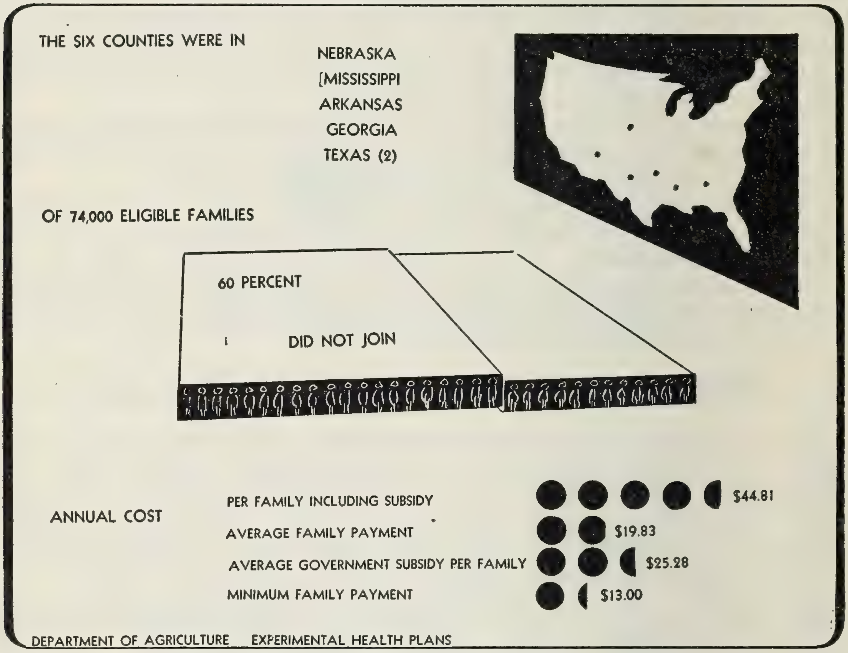
people,
ven the

luntary
his is a
rk can
people:

counties. (See table 11.) Economic reasons ranked first. This might seem strange in view of the low cost of the plans to the farmers. The average family annual net cash income of association members, however, was only $162 in 1942. (See table 12.) The county was a relatively poor one, with a "level of living index" of 82 on a "par" basis of 100, but there are many counties like it in the United States.

Neglect or disinterest was another major reason given by families for not retaining membership. There was almost no active antagonism to the plan, and a negligible percentage gave a dislike of Government help as their reason for leaving (or not joining). Yet this was in Texas, where a particularly rugged brand of individualism is supposed to prevail.

FIGURE 15. HOW TAX-SUBSIDIZED VOLUNTARY HEALTH INSURANCE WORKED IN SIX RURAL COUNTIES



Sources: Farm Security Administration and Bureau of Agricultural Economics. All figures refer to 1943-44, the second year of operation of the experimental health associations.

TABLE 11.—*Reasons given for leaving Cass County (Tex.) Rural Health Association*

Reasons given	*Percentage*
I. "Couldn't afford cost"	41.8
"Didn't have cash at time"	5.5
II. "Interested, but just neglected to rejoin"	23.6
"Just didn't rejoin"	5.4
III. "Doing nonfarm work and thus no longer eligible"	9.1
IV. "Don't like Government help"	1.8
V. Other reasons	12.8
Total	100.0

Average annual payment per family
$11.77
25.47
7.88
9.50
6.06
21.63
11.02

on County

an Hagood,

Agricultural
Department

s in the
care as
method

EXISTING TAX-SUPPORTED MEDICAL SERVICES

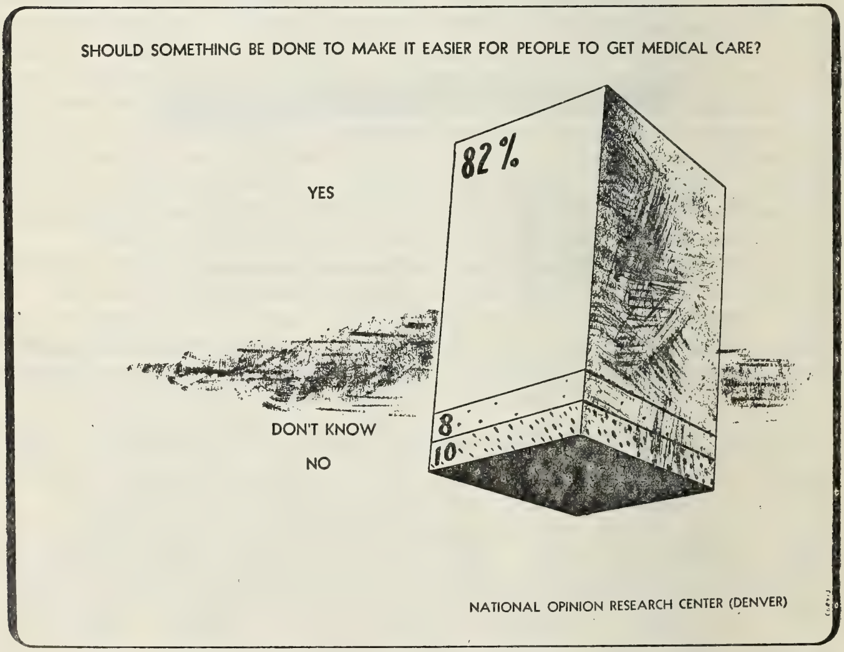
While most of our day-to-day medical care is not supported either by taxes or social insurance, enough of it is so that no one needs to be horrified if the American people decide that they want the amount of such care increased. Twenty percent of all medical expenditures, exclusive of those for the armed forces, are for tax-supported medical services. Veterans, merchant seamen, and Members of Congress are entitled to part or all of their medical care at Government expense. The agricultural workers' health associations of the War Food Administration and the Farm Security Administration-sponsored voluntary health associations for low-income farmers are examples of well-run Federal medical care programs. Over 70 percent of all hospital beds in the country are tax-supported, including general, tuberculosis, and mental beds. Public health departments, workmen's compensation, medical care for the needy, and school health activities are other examples of State or local tax-supported services.

PUBLIC OPINION

Various public opinion polls show that the public believes:

1. Something should be done to make it easier for people to get medical care when they need it. Eighty-two percent said, "Yes"; only 10 percent, "No." (See fig. 16.)

FIGURE 16. UNITED STATES OPINION ON COSTS OF MEDICAL CARE: I



2. Something should be done to make it easier to pay doctor and hospital bills. Sixty-three percent said, "Yes"; only 11 percent, "No." (See fig. 17.)

NCETON)

CONCLUSION

Our health needs are urgent. Each day we fail to achieve the proper solution exacts its toll. We must resolve that the lessons of the selective service rejection rates will not be lost upon us, that never again will we allow sickness to cripple our people to the extent it now does. As a nation, we cannot afford to gamble with our health.

Some say that we are the healthiest nation in the world, and that therefore nothing need be done. There is little evidence that we are the healthiest country in the world. We do not rank at the head of the list in any of the major health indexes—crude or age-specific death rates, life-expectancy rates, infant and maternal mortality, or even of some of the comparable disease-incidence rates. But even if we were, it would not excuse our health failings.

Even before modern medicine had reached its present peak of complexity and specialization, the fee-for-service, individual practice method of providing medical care did not meet the Nation's health needs. Now it is a complete anachronism. It results in barriers to good health care which keep not only low-income people, but most middle-income families, from the fruits of modern medical science. It inhibits the full use of modern preventive medicine since it forces most people to wait until they are seriously ill before going to a doctor. And it leaves any family the prey of unexpected crippling costs from medical bills and wage loss. On top of the natural tragedy of illness may be heaped economic catastrophe.

The need for health insurance has become clear. The well-tried American way of meeting the hazards of life by spreading risks and by prepaying costs is applicable to health services.

For a century and a half the American people have experimented with various ways of insuring themselves against the costs of medical care. Voluntary group prepayment plans of various sorts have been devised for certain occupational or other selected groups, and for certain types of medical service. In the last 20 years, the growth of these plans has accelerated, but they still provide only 3 or 4 percent of the population with relatively complete medical services. Some say that since the voluntary plans are growing, ultimately they can meet the need. We do not deny that they are growing. Those who think as we do helped build them, against the opposition of the standpatters who 15 years ago were attempting to block their growth and labeling even such voluntary systems "socialized medicine." We also agree that they have certain potentialities for further growth.

However, we are firmly convinced, for reasons we have given in this report, that they can never meet the total need.

* * * * * * *

In its third interim report this subcommittee stated:

> In order to meet the requirements of the public and of the professional groups concerned, any method (of health insurance) which is evolved should offer complete medical care, should be reasonable but not "cut rate" in cost, should include substantially all of the people, should afford the highest quality of care, should permit free choice of physician or group of physicians, should allow democratic participation in policy making by consumers and producers of the service, should be adaptable to local conditions and needs, and should provide for continuous experimentation and improvement.

nt to us
does it
hich will

ble pur-
ne prob-
veloped
ducated
surance.
cal and
cal care.
perform
nsurance

od risks,
the city
the rich
*lusive as
ical care.
rity fund*
ill satis-
sible the
y health

ient and

enough for the adoption of a national health program. The costly lessons of the selective service rejections and of the armed forces medical discharges have made this apparent.

Today America faces the challenge of world leadership. To a very large extent we bear the principal responsibility for the kind of world we are to live in. America can continue neither prosperous nor secure unless her people are healthy and full of strength. We owe it, therefore, to the Nation, and to every man, woman, and child in it, to open to every citizen the door to the marvels of modern medical care. Only thus unhindered by the heavy drag of sickness and ill health, can we make our full contribution to a free and happy world.

Claude Pepper.
Elbert D. Thomas.
James E. Murray.
George D. Aiken.

Senators Taft and Smith dissent from some of the findings and conclusions of the report.

Senators Hill, Tunnell and Morse, because of the pressure of other business, have not completed their study of the subject of this report.

STATEMENT OF SENATOR ROBERT F. WAGNER, NEW YORK

For the past several weeks this subcommittee has had the opportunity to obtain all the facts and shades of opinion on one of the fundamental long-range problems facing this Nation—how to protect and improve the health of our people.

You have come to know of the great need of our people, not only those of low incomes but the many millions in the middle-income groups, for adequate medical care and security against the economic drain of disease. As one of its sponsors I am convinced more than ever that the National Health Insurance and Public Health Act of 1947 provides the only practicable program to deal with the problem.

I shall not burden you with the detailed argument which you can find extensively spread in the testimony of the experts who have appeared before you. I want only to affirm with all the conviction that I can command that the national-health bill is deeply rooted in the rich soil of American democracy, both as to the objectives it seeks to achieve and in the methods it proposes to employ for their attainment.

We should not be unduly perturbed by the vicious attacks of its misanthropic enemies that the national-health bill is communistic and un-American. Every measure for social welfare to improve the lot of the people has been stigmatized with this accusation. In no other case is the charge more palpably false.

Individualism, no doubt, is basic to the American way of life. In some quarters, however, it has been distorted into a doctrine of jungle morality, echoing Cain's denial that he was his brother's keeper. I prefer to believe that the true concept of American individualism is expressed by the Judeo-Christian ethical precept of the worth of the individual and the sacredness of his life. A man's life and that of his wife and children are no less sacred and no less worth saving because he does not happen to be in the income brackets in which ade-

ence joy
s to the

sic con-
idenced
, consti-

to pay,
charity.
care is
It can
rinciple
erative
bill im-
ment is
ve done
nd indi-

cal tra-
health-
health
the dis-
d local
l, local,

the traditional American way of doing things. On the present world stage the eyes of the people everywhere are upon America to observe whether we can provide security, the new imperative of our age, within the framework of freedom and democracy. If we are to emerge successful in the titanic struggle of political ideas and systems, the national-health bill is a must.

Let us pass it without further delay.

STATEMENT OF SENATOR J. HOWARD McGRATH, RHODE ISLAND

Early in June 1947, Raymond Rich Associates, a firm of unquestioned standing and probity, submitted its resignation as public relations counsel of the American Medical Association. In so doing this firm took the unprecedented action of publicly announcing the reasons why it could no longer serve the AMA. These reasons were, in effect, that the AMA does not honestly represent the doctors of America and in fact refuses to carry out their instructions.

This incident, together with the testimony thus far presented during the hearings on S. 545, the Taft Act, and on S. 1320, the National Health Insurance Act, has greatly strengthened my support of S. 1320. The Rich incident brings to light the differences between our doctors and their official spokesmen; the hearings have brought out our great differences of opinion between our people and the representatives of the AMA.

The spokesmen for organized medicine and the spokesmen for lay organizations have consistently differed over the following issues:

1. Shall the Congress require as a matter of basic law that a national health program be run by a medical man?

The AMA and picked representatives of its affiliates who have appeared before this committee have said yes. Professional organizations of public health officials and social workers have said no. But the loudest "no" has come from spokesmen of organizations that represent just ordinary people—workers and farmers.

2. Shall the Congress postpone a far-reaching program until voluntary prepayment programs have had a chance to prove whether they can meet the need?

AMA spokesmen have said yes, but have spoken of voluntary programs only in reference to those programs that either were run by the doctors or approved by them. Other witnesses have consistently said that these programs were not adequate and could not be adequate.

3. Shall the Congress enact a national health program that will permit a State to divert Federal money to a single type of program or shall the Congress provide that all proper medical service organizations whether consumer, or farmer, or worker, or doctor owned be given equal opportunity?

AMA spokesmen who have differed on other sections of the Taft Act, evidently all agree on the provision which makes it possible for a State to designate one and only one prepayment plan as the recipient for Federal funds. Other witnesses have pointed to the antimonopolistic character of S. 1320, the National Health Insurance Act, and have indicated their desire to see continuing experimentation in the field of medical care organization.

ividual
earings
merican
doctors.
545 and
conomic

differed
. This
assume
judging
of his
icine in

Dakota
mn the
Society
ntatives
vith the

s which
indicate
bide by
on—the
ance to

solely the needs of nonprofit organizations whose principles and purposes were in the public interest. The experience of the senior associates prior to that time aggregate 17 years in commercial fields and 65 years in editorial and advertising work. The organization has served as counsel to groups as diverse as the New York Law Society, the Twentieth Century Fund, and the Council of State Governments. Its reputation and ability are unquestioned.

Let me tell the committee how these documents came into my possession. They came to me without solicitation through a doctor who received them from a member of the house of delegates of the AMA. He was sufficiently incensed by the story contained in them to ask that they be made public. At the same time he was sufficiently fearful of the powers of the officials of the AMA to refuse to allow his name to be attached.

Since receiving them I have satisfied myself that they have a definite bearing on the position of organized medicine on the two health programs now before Congress. I am making these documents a part of this record out of the conviction that the story involved should be known to every doctor in the country and to every man in public office who has any dealings with the lobbies of organized medicine and to every citizen who is concerned with the health of the people of this great Nation.

At the conclusion of my testimony, I desire to have them recorded in full in the record of this hearing.

Raymond Rich Associates is an eminently respectable public relations firm which was retained a number of months before the 1946 convention of the AMA to, and I quote—

> * * * study the public relations of the associations and to make recommendations for their improvement.

At the December 1946 meeting of the house of delegates, the major recommendations were adopted. Yet in June 1947 Raymond Rich Associates resigned.

Why did Raymond Rich Associates resign? I quote from the telegram which was sent to the speaker of the house of delegates of the AMA on June 12:

> Stated simply, the association has yet to take unequivocal and effective action on the policies which it adopted on our recommendation last year: to seek the truth on the economic and social aspects of medicine, to put the public first, and to become adequate in its responsibilities.

In the same telegram of resignation, Raymond Rich Associates declared:

> As our May 24, 1947, report to the board of trustees points out, basic steps in the approved programs have not been taken in spite of our repeated urging that the AMA has submitted itself publicly to the test of accomplishment.
>
> The issue is, therefore, clear: the very integrity and sincerity of the association are at stake.

To question the "integrity and sincerity" of a client is a serious charge, yet that is the charge this respectable firm makes against the officers of the AMA, which, we have been assured during these hearings, represent 80 to 90 percent of the doctors of the United States.

There are three major conclusions at which I have arrived as a result of the study of these documents:

ubstan-
tee that
rship in
e.
ch they

een both
spects of
ally of a

ation of
ociation
te from

is “seek-
s it is in
ls, a fair
hose who
believe

Medical
he truth
o all the
nt of the

dequate.

developed with the cooperation of the physicians of the country who, surely, have much to contribute with reference to these facts.

5. In relationship to the latter portion of section 2 of the national health program, we believe that it might prove fruitful to study possible methods, economically sound, for integrating under the prepayment plans medical care for all those unable to pay.

6. In connection with sections 3 and 4 of the national health program, a similar study might be made of economically sound methods for coordinating maternal and infant care with voluntary plans.

In short, it seems to us urgent that the work of the bureau be focused more sharply on projects which will bear clear witness to the AMA's determination to find the truth in matters of medical economics, in forms which can be applied for the benefit of the people.

Moreover, we must observe that there is as yet no department of medical economics in the journal. There have been only occasional articles, few if any of which, we regret to say, seem to us new contributions to thought regarding the economic and social aspects of medicine. Furthermore, there has been, in our view, no substantial improvement over previous years in providing for fair hearing of intelligent diverse viewpoints.

Again, I would like to interrupt the quotation from the Rich statement to comment that this lack of democracy has been one of the most telling comments of witnesses who have opposed the AMA point of view.

In summary, we believe that the association's advance toward the first goal through the work of the bureau has not yet been sufficient to contribute appreciably toward improved public relations.

We recommend [emphasis added] therefore that provision be made for closer supervision and guidance of the bureau of medical economic research—possibly by a special committee of physicians with an ancillary group of eminent economists—*with a view to stepping up its contribution toward finding the truth* [emphasis added] in these vital fields.

Second and third goals [reading]:

Let us turn now to consider the progress that has been made toward the second and third goals—to put the people first by following up the truth that is found, and to become adequate in that performance.

We assume that the truth which the association has found in economic and social fields prior to the reorganization of the bureau of medical economics is incorporated in the national health program—the 10-point program. Until further truth is discovered, this program must not only be promoted but promoted and implemented adequately. Otherwise the AMA lays itself open to the charge that it acts upon only a portion of the truth it finds.

We regret to say, however, that in no other field—with the possible exception of the recommended coordination of the association's public relations, detailed below—has the progress of the association been less satisfactory.

We are aware that certain points of the program have been implemented to a degree—and particularly those covering health education and cooperation with other organizations. Moreover, State and county societies have, in many instances, taken formal action to endorse the program. But formal action, however necessary and commendable, must not be confused with effective implementation. Therefore, with regard to points 1, 2, 3, 4, 5, and 6, we cannot escape the conclusion that implementation of the program has been gravely insufficient.

Among these important points in the AMA's national-health program is the promotion of voluntary prepayment plans. As stated in our survey nearly a year ago: "It is obvious that voluntary plans for medical care must be developed with sufficient rapidity and success to meet the needs of the Nation, if compulsory health insurance is to become unnecessary. The fact that relatively so little is yet being done to promote these modern measures reveals amazing shortsightedness. There must be positive, aggressive drive in their behalf. They must be developed to the point where they assure virtually all of the people adequate medical care."

The responsibility for advancing the national health program rests primarily, we understand, with the Council on Medical Service. As stated in our survey,

ally and
ncement

that a
ny peo-
hich ig-
n occa-

e house

ed, first,

of pam-

ne advice

ated and

lied that

nstrated

acked by

promo-

AMA speak openly for its own membership." This is followed closely by a request that widest possible publicity be given to positive legislative proposals made by AMA or supported by AMA. Again in this field, there is a wide desire that the Washington office be made an "effective arm of the association, expanding it if necessary." There is also the recommendation that unfavorable legislation be criticized only in the spirit of constructive evaluation. Furthermore, that emphasis should be placed upon positive action in the field of legislation rather than on lobbying against proposals made by others.

Foremost is the request that haziness on matters of policy be combated by stated thoroughly and clearly new policies or changes in policy as they take place, and especially after meetings of the house of delegates. This is followed closely by the recommendation that means be found to evaluate the wishes of State societies more speedily and put those wishes into effect.

Yet, even these reasonable suggestions were not acted upon by the board of trustees, even though they had originated with the local organization of the AMA.

Now I should like to make a few brief comments on the problem of assuring our people of access to needed medical care; comments from the point of view of a former Governor who has had to wrestle long and hard with matters of health in their relation to State finances and State administration.

I am quite familiar with the problems this subcommittee is faced with because in several Rhode Island programs we have gone further in trying to meet urgent and important health problems than any other State in the Union.

I am proud of the fact that during my administration, Rhode Island enacted the first State cash disability compensation law in the United States. The Rhode Island law provides that each employee contribute 1 percent of his wages into the State cash disability compensation fund. Out of this fund cash payments are made to an employee when he is out of work due to sickness or disability. The minimum payment is $6.75 a week; the maximum payment, $18 a week. The maximum duration of benefits is 20¼ weeks. The maximum total payment is $364 in one benefit year.

The law thus provides a partial reimbursement for wages lost through illness; it helps pay the family's rent and its food bill. It helps mightily during illness. It is so successful that it has recently been expanded. But it does not and cannot assure access to medical care nor payment for that care. It proves the need for such insurance, proves that people are glad to pay such insurance, and proves that it can be properly administered.

We are also proud in Rhode Island that we have the highest proportion of population of any State enrolled in Blue Cross hospitalization plans. But these voluntary hospital plans do not cover the doctor's bills or most other types of medical costs. As a matter of fact, hospitalization costs represent only about 20 or 25 percent of the total costs of medical care. In other words, we still have a long way to go to provide comprehensive health protection to the people in our State.

I should also like to point out that Rhode Island has attempted through its comprehensive public welfare plan to provide medical care to needy persons through public assistance funds. This arrangement, while a necessity for those who become needy, by no means answers our problem. Our people in Rhode Island—like Americans

ect their
indefi-
nd local
expan-
persons,

Island
lve our
health

ed only
or—that
have an
effective
ection a

nd that
s desir-
re now
alth in-
aracter

perience

Island.

Part D of S. 1320, beginning at page 32 of the bill, entitled "State Administration", carefully spells out how the States may develop and administer their own decentralized medical-care programs.

A national plan, in my opinion, is the only way in which this program can be solved. I have thought about alternative solutions from many angles, but I always come face to face with this fact: In the United States people are constantly moving across State lines. Only a national insurance plan can cover everyone in the United States and yet at the same time assure adequate protection to our mobile population.

In my opinion, those who believe in States' rights must give the States the aid they need to meet the problems they must solve.

Those who advocate States' rights and then deny to the States the Federal help they must have are, in my opinion, the strongest supporters of eventual nationalization.

S. 1320 provides the necessary Federal action, assures the States of local control of administration, and guarantees the rights of both patients and doctors alike.

These are some of the reasons why I believe that S. 1320 merits support. I don't say that it is a perfect bill, but I do say its fundamental idea is sound. It will work.

I request that the documents previously referred to in my testimony be made a part of this record.

(The documents referred to follow:)

Raymond Rich Associates,
New York 10, N. Y., June 12, 1947.

For your information, the following telegram was sent to the speaker of the house of delegates of the American Medical Association today:

As the house of delegates is aware, we have submitted our resignation as public relations counsel to the AMA. In view of the fact that vital issues affecting the general welfare of the medical profession are involved, however, we feel obligated to inform the house of the major reasons which impelled us to take this serious step.

The facts, briefly, are these: We were engaged in February 1946 to study the public relations of the association and to make recommendations for their improvement. We submitted our report in June 1946. In September the board of trustees entered into a new contract retaining us as public relations counsel. At its December 1946 meeting, the house of delegates adopted our major recommendations with only minor amendments. Since that time, as counsel, we have done everything in our power to advance the establishment and implementation of the program you have approved.

We took this course because our survey had demonstrated the urgent need that the association take effective action on an adequate program to meet the medical needs of the American people and to promote the future welfare of the profession. Also because we believed that such action was required to fulfill the spirit as well as the letter of your clear decisions.

As our May 24, 1947, report to the board of trustees points out, basic steps in the approved program have not been taken in spite of our repeated urging that the A. M. A. had submitted itself publicly to the test of accomplishment.

The issue is therefore clear: The very integrity and sincerity of the association are at stake. In view of this situation, we recommended to the board of trustees that the association must make this vital choice: Either to verify its desire to carry out the program approved last December or to indicate its wishes regarding a more limited program. From our meeting with the trustees, June 6, 1947, we became convinced that they were not prepared to resolve this issue or to submit our report to the house of delegates as a basis for clear decision. We therefore had no recourse but to submit our resignation from a position that had become professionally untenable.

Stated simply, the association has yet to take unequivocal and effective action on the policies which it adopted on our recommendation last year: To seek the

ne house
Ve shall
ber who

s,
1947.

tees, we
ns made
stant to
division.
ntion to
ation at

es which
al of all
at when
had to
for that
vould be

xecutive
are con-
lic rela-

y of its

3. In addition, the house of delegates approved our recommendation that a competent promotion expert be engaged when necessary "subject to cost and demonstrated need." The executive assistant believed, and we concurred, that the need had been proven. The 10-point program must be promoted, must be implemented, if the AMA is not to be laid open to the charge that it acts upon only a portion of its beliefs. (My further comments upon this point were presented to the board on February 21 and are incorporated in a memorandum which already has been transmitted to you.) *The item for this promotional expert was also stricken from the budget.*

Under these budget decisions the executive assistant is left with a staff consisting of one senior and one junior assistant and one stenographer to carry on the new program. (The previously existing unit of three—one senior, one apprentice, and one stenographer—which was transferred to his jurisdiction, is only incidentally available for any of the expanded program since its earlier duties continue.) In our best judgment, that is hardly enough personnel to deal with routine operations. Even with superhuman resolve and protracted overwork, it would be physically impossible for a staff of this size to do the job we believe the AMA desires done during the next few critical years.

That is why we say that the board's excision of all these items makes it *impossible to carry out the expanded program.* If not corrected soon, it will almost inevitably lend force to the contention of critics in and outside the AMA that the association does not genuinely intend to carry out its new policies.

A more serious consequence is that the reduced budget will prevent the AMA from aiding and guiding the public-relations programs of its component societies. Those bodies are now spending, in the aggregate, many times more than the full budget requested by the executive assistant. They are expending at least 10 times the amounts granted for public relations by the board of trustees. They desire public-relations aid, cooperation, and counsel from their national headquarters. Is the AMA going to deny a large proportion of their requests and thereby forfeit its opportunities for leadership in this field?

Finally, we would emphasize once again the statement made on several occasions in conference with the board of trustees and which was implicit in the report of our survey: *The public relations of the association are in a critical state.* To be successful the movement to improve them must have sufficient force to be effective. To cite just one major problem: national health legislation, to which the AMA objects, may be stalled temporarily; but it will come up again and again until the problems from which it arises are met in some adequate fashion. The AMA must take the lead with a vital and adequate national health program if it is to have strength in the midst of changing conditions and, particularly, *if it is to make Government control of medical economics unnecessary.* Good public relations require enlightened conduct.

Because the present situation seems to us most serious, we respectfully request that this matter be placed on the agenda of the next meeting of the executive committee. We are sending copies of this letter to the other members of the board, to the ex officio members, and to the general manager and his executive assistant. We trust that they, as well as yourself, will appreciate that we have written this letter out of a sincere desire to promote the best interests of the association which we are honored to serve as counsel.

Sincerely yours,

RAYMOND RICH ASSOCIATES.

REPORT ON PUBLIC RELATIONS TO THE TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION, MAY 24, 1947, BY RAYMOND RICH ASSOCIATES

As the trustees know, our agreement to provide counsel on the public relations of the American Medical Association expires on June 30, 1947. It is fitting, therefore, that we report our observations on the work of the past 8 months as well as our recommendations regarding next step in these matters.

We are submitting this report at the present time in order that it may be considered in advance of the Atlantic City meetings. And we believe the trustees will agree that it will best serve the interests of the American Medical Association if we speak with as much candor now as we did in June 1946, when we concluded our survey assignment.

It will be recalled that as a result of that survey, we recommended the following basic measures:

cientific
s doing

'a truly
for the
naterial
oppor-
rder to
interest
oncern."
dequate
elations
of the
ays and
ociation

s) that,
lic-rela-
must be

at it is
nedicine
n these
be given
wpoints
tention.
n Medi-
e truth
e to all

(3) Yet again the bureau should study the possibilities from an economic and insurance standpoint of extending the coverage provided by existing prepayment plans, with respect to: (*a*) Income brackets of the subscribers; (*b*) possible bases for determining equitable surcharges for subscribers having income above the brackets covered by the plan; (*c*) adding medical service in plans providing at present only for surgical care.

(4) Furthermore, if sufficient experience as to the incidence of need for medical care is unavailable, the bureau should ascertain how these data might be soundly developed with the cooperation of the physicians of the country, who, surely, have much to contribute with reference to these facts.

(5) In relationship to the latter portion of section 2 of the national health program we believe that it might prove fruitful to study possible methods economically sound for integrating under the prepayment plans medical care for all those unable to pay.

(6) In connection with sections 3 and 4 of the national health program a similar study might be made of economically sound methods for coordination of maternal and infant care with voluntary plans.

In short, it seems to us urgent that the work of the bureau be focused more sharply on projects which will bear clear witness to the AMA's determination to find the truth in matters of medical economies, in forms which can be applied for the benefit of the people.

Moreover we must observe that there is as yet no department of medical economics in the journal. There have been only occasional articles, few if any of which, we regret to say, seem to us new contributions to thought regarding the economic and social aspects of medicine. Furthermore there has been, in our view, no substantial improvement over previous years in providing for fair hearing of intelligent diverse viewpoints.

In summary we believe that the association's advance toward the first major goal through the work of the bureau has not yet been sufficient to contribute appreciably toward improved public relations.

We recommend, therefore, that provision be made for closer supervision and guidance of the bureau of medical economic research—possibly by a special committee of physicians with an ancillary group of eminent economists—with a view to stepping up its contribution toward finding the truth in these vital fields.

Second and third goals

Let us turn now to consider the progress that has been made toward the second and third goals—to put the people first by following up the truth that is found, and to become adequate in that performance.

We assume that the truth which the association had found in economic and social fields prior to the reorganization of the bureau of medical economics is incorporated in the national health program—the "ten point program." Until further truth is discovered this program must not only be promoted but promoted and implemented adequately. Otherwise the AMA lays itself open to the charge that it acts upon only a portion of the truth it finds.

We regret to say, however, that in no other field, with the possible exception of the recommended coordination of the association's public relations (detailed below), has the progress of the association been less satisfactory.

We are aware that certain points of the program have been implemented to a degree, and particularly those covering health education and cooperation with other organizations. Moreover, State and county societies have, in many instances, taken formal action to endorse the program. But formal action, however necessary and commendable, must not be confused with effective implementation. Therefore, with regard to points 1, 2, 3, 4, 5, and 6, we cannot escape the conclusion that implementation of the program has been gravely insufficient.

Among these important points in the AMA's national health program is the promotion of voluntary prepayment plans. As stated in our survey nearly a year ago:

"It is obvious that voluntary prepayment plans for medical care must be developed with sufficient rapidity and success to meet the needs of the Nation, if compulsory health insurance is to become unnecessary. The fact that relatively so little is yet being done to promote these modern measures reveals amazing shortsightedness. * * * There must be positive, aggressive drive in their behalf. They must be developed to the point where they assure virtually all of the people adequate medical care."

survey,
and the

ted that

goals by
e greatly
to it by
the past
esources
nt of the

toward
We be-
one final

need of
medical
associa-
ciation's
er which

Search for candidates

In view of this statement we were quite willing to undertake upon the request of the general manager, and without charge, an extensive search for the best available candidates for the position of executive assistant. We sought men who offered (1) wide experience in nonprofit fields and (2) proven capacity to plan and direct programs involving budgets of from $100,000 to $200,000 per year.

We submitted two candidates.

The first candidate declined the offer made to him, and, as we reported informally to the general manager, the chief reason was apparently that, after conferring at AMA headquarters, he did not feel convinced that there was a sincere desire for an effective public-relations program.

The second candidate, Mr. Charles M. Swart, was interviewed by officers of the association and was offered the position of executive assistant to the general manager. He accepted after he had read the chairman's San Francisco statement and the other San Francisco proceedings and after he had been assured that he would have "sufficient personnel to carry out this program adequately." Moreover, in view of the expected scope of his duties, the association set the salary at $15,000 per year

Tenative budget

After a period of orientation in our headquarters, Mr. Swart reported for duty at AMA headquarters on November 25, 1946. Contrary to an impression in some quarters, he was not and never has been in our employ.

He was faced immediately with the duty of preparing a tentative budget for a portion of the new year, pending detailed action by the house of delegates upon the recommendations in our survey.

Just prior to the convening of the house in December, the board approved a small, initial, and strictly tentative budget which, with respect to staff, provided only for Mr. Swart's salary, a liaison and editorial assistant, a junior writer, and a secretary.

House of delegates' action

During the ensuing days, the house of delegates, acting as committee of the whole on our survey recommendations, voted[2] with respect to staff for the executive assistant as follows:

(*a*) "To engage a competent person to conduct a centralized service of pamphlet production."

(*b*) "That all possible uses of visual techniques be utilized backed by the advice of professional counsel."

(*c*) "That the speakers' bureau should be not only initiated but activated and utilized to its fullest capacity."

It seemed obvious to us that each of these actions of the house implied that adequate personnel should be engaged to implement its decisions.

In addition, the house of delegates approved, subject to cost and demonstrated need, our recommendations:

(*d*) "That provision be made for a junior radio specialist on the staff, backed by highly experienced professional counsel."

(*e*) "That the executive assistant be enabled to engage a competent promotional specialist."

Final budget

In light of the unconditional house approval of three additional staff members, the executive assistant, in response to the request for a final budget in February, included provision for (*a*), (*b*), and (*c*) above.

Furthermore, the executive assistant, included provision for (*e*) above. He believed, and we concurred, that the need for a promotional specialist had not only been proved but also was recognized by the board. This for the reason that the chairman of the board in San Francisco had reported[3] with apparent approval our survey recommendations stressing the basic importance of the national health program and the need for developing it in the centennial year.

At its February meeting the board rejected all three items and made other heavy reductions in the proposed budget for the office of the executive assistant.

---

[2] J. A. M. A., vol. 132, No. 17, pp. 1089, 1090.

[3] J. A. M. A., vol. 131, No. 12, p. 997.

reason
ted and
d to be
realized
public-
iewpoint

tion left
$15,000
anwhile,
a large
ny other

not ad-
e budget
ver, the
fend his
ction on

r survey
admin-
st "have
when he
aspects

ant and
rence to
correct,
s of the

solve and protracted overwork, it would be physically impossible for a staff of this size to do the job we believe the AMA desires done during the next few critical years.

"That is why we say that the board's excision of all these items makes it *impossible to carry out the expanded program.* If not corrected soon, it will almost inevitably lend force to the contention of critics in and outside the AMA that the association does not genuinely intend to carry out its new policies.'"

Since our request for a reconsideration of the budget was granted, the executive assistant submitted to the general manager the memorandum appended hereto as appendix B, and your counsel appeared with him before the executive committee on April 25, 1947.

The executive committee stated, however, that it could take no action and requested our appearance before the full board at Atlantic City in June.

Alternative courses for the future

Hence, at present, the public-relations program of the association stands in an untenable position. If, last July, we had been advised that only about $55,000 would be available for its support, our staff recommendations would have been different. And if we had been advised of the limitations last December, the planning by the executive assistant and ourselves would have been basically different.

The program that was approved by the house of delegates last December cannot be conducted under the restricted budget voted by the board of trustees. If the association still desires this program, it must undertake to provide at least the minimum funds necessary to make it possible.

On the other hand, if the association does not now wish to carry out the expanded program, or cannot find the necessary funds, then the program and staff will both have to be completely replanned to conform with the new situation.

We recommend, therefore, as a matter of utmost importance that the trustees and the American Medical Association make a clear choice at the June meeting between two courses of action:

1. Provide an adequate appropriation to enable a program substantially as recommended by the executive assistant and ourselves at the April meeting of the executive committee—approximately $75,000 for 1947 and $127,000 for 1948, or

2. Determine what maximum amounts, less than the above, can be allotted for 1947 and 1948 and take steps toward the basic replanning of the association's public-relations program to conform with these limitations.

Inability to follow the first course would be highly regrettable. But, if necessary, a new plan of limited operations, under a revised concept, could be developed.

WHAT THE CONSTITUENT SOCIETIES DESIRE

In any planning or replanning of public-relations activities, it is highly important to take into account the desires of the constituent societies. As we pointed out in our letter of April 8, these bodies are now spending in the aggregate many times more than the full budget requested by the executive assistant. They are spending, we have ascertained, well over $600,000, perhaps nearer $800,000.

Six months ago, therefore, we asked all State society secretaries and the secretaries of a few large county societies to tell us what they most wanted to see in the AMA's public-relations program. More than 40 sent confidential replies; all but 4 offered detailed suggestions.

Many of the desires expressed by the societies were reflected in the advice which we gave to the executive assistant and hence in the recommendations submitted to the board of trustees in February. Since the required funds were not available, however, and since it appeared that a reduced program might become necessary, it seemed essential to determine priorities of importance among the many suggested program elements.

In April, therefore, we embodied all the suggestions in a composite checklist (see appendix C). We then submitted this list to the society secretaries with an invitation to indicate their ideas of the relative importance of the component parts.

The response has been most favorable in all but two cases. Secretary after secretary has urged that most, if not all, of the suggestions be given effect. A few quotations will illustrate this point.

From State societies:

seem to

services
e would

opinion
see a
hem *all*

tremen-
o bring

diately,

rgently

ling of

d pub-
accom-
al-care
eleases
l infor-
, make
ational
nd the
ference

t socie-
vity in

CONTINUED NEED TO GIVE LEADERSHIP

The confidential communications which we have been privileged to receive from constituent and component societies of the American Medical Association during recent months clearly indicate that they desire help and leadership. They underscore the validity of the statement made in our original survey that "State and local leaders are eager for aid and leadership. They do not want to be directed or told they must follow a certain line, but they are always reaching out for patterns which they may assimilate and later consider their own."

Again, because it continues to have such pertinence to the present situation, we would reiterate additional comments which appeared in our survey of a year ago:

"An organization cannot hope to be recognized as a leader if it has not mobilized its own resources to this end. * * * State representatives have told us repeatedly that they miss the leadership which they believe headquarters should give. * * * Therefore, continued hesitancy in giving leadership to the constituent societies would be inherently weak. A positive policy could be exceedingly strong if it were developed democratically and implemented with intelligence, imagination, and skill."

Yet more, we would emphasize the assertion in our letter of April 8 to the board of trustees that if the public relations of the association, which are now in a critical state, are to be improved successfully, the measures taken must have sufficient force to be effective. The AMA must take the lead with a vital and adequate national health program if it is to have strength in the midst of changing conditions, and particularly if it is to make Government control of medical economics unnecessary.

In the history of the association which Dr. Fishbein has been writing, he emphasized that since its beginning the American Medical Association "has kept abreast of the professon in its development."

This does not seem to us enough. And we would quote as the most vivid expression of this judgment a report received from a strong Middle Western medical society:

"There is now a feeling that, since it (the association) is fully organized and functioning smoothly, it should set the pattern for the profession, with advanced planning. To lead in this manner, it is felt that our national organization must be willing to concern itself more than previously with problems of national importance, even if they be only little concrned directly with health. In other words, the American medical profession, having now come fully of age, the organization which represents it must in most mature fashion be a part of the total society of this Nation, not apart from it."

This challenge obviously applies to activities in the field of medical economics and social medicine. It also applies, and indeed it was particularly written with reference to the public relations of the association. In our best judgment, the AMA cannot long afford either to ignore this challenge or to seek to meet it with the inadequate measures thus far taken.

* * * * * * *

It is our deep regret, which we are certain is shared by most of the trustees, staff, and membership of the association, that the past year has not seen greater progress in these fields. We recognize, however, that change in the attitudes and affairs of a great association which is comprised of men holding many diverse views must inevitably come slowly. The past year's work has done much to clean the seed and prepare the ground. We trust that the coming year will witness a great planting and a rich harvest.

Respectfully submitted.

RAYMOND RICH ASSOCIATES.

APPENDIX A

NOTE WITH REGARD TO THE NATIONAL PHYSICIANS COMMITTEE

It will be recalled that the "Special Committee on Executive Session for Consideration of the Rich Report" submitted the folowing findings to the house of delegates last December.

"This committee recognized: (1) That each member of the American Medical Association is primarily a citizen with the inalienable right to join any organizaton. (2) That the house of delegates has on two previous occasions endorsed and commended the work of the National Physicians Committee for the Extension of Medical Service. (3) In line with the new program in the process of accomplishment, this committee feels that the American Medical Association should

izations
(4) In
of lack
ttee for
study of

vised of
th refer-
ntiated.

ertinent
careful
l, is one

ere pre-
ysicians

elegates,
rnal.
rization
ll stand

947, and

s state-by district or local public-health departments, and in a third of the counties that were serviced, there were no health officers. Twenty-three of the States do not have even a single local public-health unit that measures up to minimum medical experience and training standards. Instead of the one to two dollars per capita required to provide adequate preventive services, rural areas are spending 50 cents. Is it any wonder that, with this lack of provision for adequate preventive health services in rural areas, preventable diseases still take an inexcusable toll of life?

Title II of our bill, the title on "Development and Expansion of Health Services," would provide means for correcting these very deficiencies. The Federal grants-in-aid to the States for expanded preventive health services, for maternal and child health services would come as a blessing to those millions of rural residents who do not now have the protection of full-time, adequately staffed and well-financed public-health departments.

Not only can programs for the control of tuberculosis and the venereal diseases be strengthened and extended, but impetus would be given to the establishment and maintenance of programs for the early detection, prevention, and treatment of mental disorders, dental disease, cancer, heart disease, and other diseases of our aging population.

In addition to adequate preventive services, our rural people are vitally interested in having access to hospital beds and in having enough physicians, dentists, nurses, and other health workers available to serve them. Congress has taken cognizance of the inadequacy of the Nation's hospital facilities by its passage of the bipartisan Hospital Survey and Construction Act. I am not sure, however, that the great disparity between rural and urban areas in this regard is generally appreciated.

Generally speaking, rural States have about half the supply of hospital beds found in the highly industrialized and urban States. Moreover, rural hospitals are usually small, poorly equipped, and without free beds since they are often privately owned.

Large cities have a 60 percent higher rate of hospitalization than do farm areas, and this lower hospital-bed occupancy exists in those very areas that have the fewest hospital beds. This is not because farm people need or desire less hospital care, but because they are less able to afford to purchase it.

The construction of hospital facilities under the Hospital Survey and Construction Act by itself will not bring sick farmers into the hospital. As a matter of fact, even for construction to be undertaken under that act, proof must be shown that the hospital can be maintained—a difficult task in a low-income rural county. A prepayment system that removes the economic barrier to hospital care and guarantees a community purchasing power to furnish the necessary maintenance is provided for by our bill.

In title II there is the provision that hospitals would be paid their full cost of service. In addition, the amount of money authorized under the Hospital Survey and Construction Act is increased and the span of its authority is extended from 5 to 10 years.

The need for physicians, dentists, and other health personnel in rural areas is acute. They have 43 percent of the population but only 18 percent of the health workers of the country.

ly one
ation is
armed
y rural
against
ounties

means
on why
ng ade-
health

special
reas by
rtation
as, and
ipment.
expen-
p basis

gh cost
insur-
d when
average
of the

ance plans. Cooperative plans for the distribution of medical care have been very successful in many rural areas and our farmers will fight any attempt to prohibit the continued development of these plans in a democratic fashion.

Finally, S. 545 would set up a double standard of medical care—one for the rich and one for the poor. Since so many of our farmers are unable to meet high costs of medical care, they will not support legislation which at best would provide medical care of an inferior quality.

Therefore, in the interests of our Nation as a whole and particularly because it is badly needed by our farmers and their families, I urge prompt and favorable action on S. 1320, the National Health Insurance and Public Health Act of 1947.

STATEMENT OF SENATOR DENNIS CHAVEZ, NEW MEXICO

I am glad to take this opportunity to present the reasons which led me, as a Senator from the State of New Mexico and as reflecting the views of the peoples of our great Southwest, to join with Senators from Montana and New York, from Florida, Rhode Island, and Idaho in sponsoring S. 1320, and the reasons why, under my obligations to the Nation and to the people of my State, I must oppose S. 545.

Fortunately, one no longer has to argue over whether or not there is need for Federal action to assure our people of access to modern medical care and of a chance to maintain the good health which that care makes possible. Experts and statisticians have produced volumes of figures proving that our people are not getting the care they should.

During the last two sessions of Congress, both the existence of this need and the absolute necessity for Federal action in meeting the need have been recognized by leaders of the Republican Party as it had been long before by men of my own persuasion. This session has seen the introduction of S. 545, sponsored by Senators Taft, Ball, Smith, and Donnell, and of S. 1320, sponsored by Senators Wagner, Murray, Pepper, Taylor, McGrath, and myself. The need and the need for action has been agreed upon.

But the proposals set forth in S. 545 are so unsatisfactory that I am sure its sponsors cannot really have been aware of either the very great extent of the need in the Southwest or of the methods of meeting that need which would be acceptable to the people of the Southwest. It is on these points that I should like to comment. My colleagues will, I am sure, address themselves to the conditions pertinent to those varied sections of our great Nation which they represent.

New Mexico is a most fortunate State in most respects. Our people are rich in their cultural heritage, richly endowed by the climate and character of the land in which we make our homes, rich beyond measure in their deeply satisfying ways of living.

But New Mexico is an agricultural State and our people are not rich in the common usage of the word—in dollars. Recent figures indicate that the average effective income for each family in New Mexico in 1941 was only $1,435. That was but 67 percent of the national average of $2,133. In 1944, although the corresponding cash figures had almost doubled, New Mexico still stood at only 70 percent of the national average.

know-
e that
f even
ne and
a bill
opula-
to 90

actory
o. At
ion of
spond-
2,449
sician,
s. At
prac-

prove-
whole
physi-
ocated
y have
f high

ve the

ard of medical care—one for the low income and another for those of wealth.

The people of New Mexico know that there is only one acceptable standard of medical care. We do not want to see separate systems of medical service, one for those who can afford to pay well and another for those who cannot, established in their State or for that matter anywhere in our Nation.

Such a proposal is archaic, a return to the Elizabethan Poor Laws of 1604. Those people needing medical care the most would scorn such a policy before bowing to the humiliation of accepting charity. They would rightfully resent the prying of the investigators who would be required to execute S. 545.

To the people of New Mexico, S. 545 means degradation, dependence on charity, poor medical care, and a compulsory tax on all the people for the questionable benefit of a few. Such legislation is abhorrent and no solution to a problem affecting over 90 percent of all the families in New Mexico.

The Senate subcommittee reporting on the 1939 Wagner health bill said, among other things:

> Poor health leads to unhappiness, poverty, dependency, and even to crime; good health contributes to well-being, production, income, and wealth. The ideals and principles of American democracy call for equality of opportunity. Such equality of opportunity certainly cannot exist unless all groups in the population have access to those health services needed to prevent and cure disease, and to promote vitality and well being.

The right of all the people to medical care, which S. 545 ignores, makes this bill even more intolerable.

In contrast, S. 1320 really recognizes the basic philosophy of making medical care available to all the people. It rests on the right of the individual to health and on the economic need of society for a healthy population—one which is fit and able to produce.

S. 1320, as opposed to S. 545, would entitle practically every American family to medical care as a right, when it is needed, in return for contributions made while well. This is an extension of the social security principle which has already been accepted by the American people to replace the antiquated poor law system which S. 545 so closely resembles.

S. 1320 permits our people, along with those of every other section of the country, to proudly pay the proper percentage of their incomes for their medical care; it assures the man earning $1,000 a year or $1,500 or $2,000 that he is doing just as much to insure the health of his family and of the Nation as is the man earning five or ten thousand; it enables him to seek and to receive medical care on the same rightful basis as any other man.

S. 1320 assumes even greater significance when the administrative aspects of the bill are reviewed. I shall leave a complete review of this phase to my colleagues. However, I should like to indicate in passing that S. 1320 very adequately and properly recognizes the importance of local control. In fact it provides for the distribution of health services in accordance with local customs and traditions. This, permit me to assure you, is extremely important to New Mexico. It is an amazing incongruity that such provisions are not apparent in S. 545.

st ap-
uality
s seem
dicta-
overn-

pendi-
g their
gives
anized
a sub-
rarchy
short

mits a
ion of
ealthy
re and
ogram

espect
rough-
choice.
e pro-
minis-

The satisfactory solution of the health problems of our Nation cannot of course be achieved by the medical profession alone. Public health services must also be included in any planning for the protection of the health of the community.

It also becomes increasingly important to give a strong voice to the consumer who pays the bill for medical services. This is not only democratic but it is good common sense to have the benefit of the experience and judgment of these groups.

If passed, S. 545 would deter us an unnecessarily long time in reaching a satisfactory solution to these problems.

It is an objectionable and undemocratic piece of legislation, while in contrast, S. 1320 provides the answer to the health problems of New Mexico and the entire country. It deserves the hearty recommendation of this subcommittee.

Senator PEPPER. Mr. Chairman, I won't ask that it be incorporated here except by reference, but I would like to have incorporated into the record at this point by reference the material appearing beginning at page 2257 of the hearings on the national health program, in connection with S. 1606, part IV, in May and June of last year, entitled "Comparative Death Rates of the United States and Other Countries," running from the middle of page 2257 of the hearings I have identified, down to the end of page 2261.

That gives a lot of data, Senator Donnell, with reference to the comparative death rates of the United States and other countries, and I am just incorporating it by reference here, beginning at page 2257 of the hearings of last year.

Senator DONNELL. By incorporation by reference you mean——

Senator PEPPER. I hereby call attention in this record to the hearings of last year, and specifically that part entitled "Comparative Death Rates of the United States and Other Countries", submitted by Mr. I. S. Falk of the Social Security Agency, beginning at page 2257 of the hearings on S. 1606 in May and June of last year, and running over to the end of page 2261, so that anyone reading this record, and interested in the subject, can turn back to the hearings of last year and see that very interesting material showing the unfavorable comparison.

I will read, if I may, Mr. Chairman, just the first paragraph of that section.

Senator DONNELL. Yes, sir.

Senator PEPPER. This material was prepared by the Social Security Board.

> Table I gives the age specific death rates for males in the specified countries where such death rates were lower than the corresponding death rate for males in the United States. The death rate of infants under 1 year of age is in terms of 10,000 live births. For instance, the table indicates that the United States death rate for infants under 1 year of age per 10,000 births in the 3-year period 1934–36 was 641. Six nations in that general period had infant death rates lower than that in the United States. These were New Zealand, Netherlands, Norway, Australia, Sweden, Denmark, and Switzerland. All the other nations for whom information was available had death rates exceeding those of the United States. The striking fact in this table is that (*a*) at no age are death rates in the United States the lowest, (*b*) the death rates in the United States are comparatively most favorable for infants under one year of age. The comparative position of the United States becomes worse as we pass from infancy to older ages. Thus, while for male infant death rates the United States is in

ss to the

, and I
orinted.

ing ex-
oon this
States
n, Den-
entirely
distinct
me.

of you

session
t inter-
indul-
ou, but

o'clock

self and Michael M. Davis, Ph. D., who is chairman of our executive committee. I will state the general program of our committee and its position on these two bills, and Dr. Davis will present in more detail our anaylses of these two measures.

We appear today to testify in favor of the National Health Insurance and Public Health Act, S. 1320, and in opposition to the Taft-Smith-Ball-Donnell health bill, S. 545. We have been authorized to do this by our executive committee, who were so instructed by resolutions adopted at the annual meeting of our board of directors held on May 9, 1947.

In supporting S. 1320 and opposing S. 545 we wish to emphasize the fact that we do not consider these two bills as alternatives. S. 1320 provides for a broad national health program. S. 545, although it is entitled "A National Health Act," is a medical charity bill masquerading as a national-health program. We are prepared to support specialized health measures which are consistent with a broad national-health program, fit into a coordinated scheme of needed medical services, and operate under a sound pattern of administration.

An examination of the list of witnesses who have appeared before you reveals a remarkable contrast between the groups of people that favor and the groups of people that oppose the Taft health bill.

All witnesses favoring the Taft bill in whole or in part were representing medical societies, dental societies, hospital associations, the Blue Cross, voluntary medical-care plans sponsored by medical societies, or insurance companies—groups who would furnish the service and be the recipients of the public funds expended.

Witnesses testifying against the bill, on the other hand, reflected the point of view of a broad cross section of our society. You have heard testimony in opposition to the Taft bill from a wide variety of organizations representing physicians, attorneys, social workers, farmers, industrial workers, veterans, women, consumers, white-collar workers, Negro, and church groups. It is therefore proper to ask, "Whom does the Committee for the Nation's Health represent?"

The purpose of the Committee for the Nation's Health, as indicated in its certificate of incorporation filed February 1946, is to promote and support legislation which will help make available good medical services to every person in the United States, regardless of race, creed, color, or economic status. The committee is registered as a lobbying organization as defined under the Federal Regulation of Lobbying Act, passed during the last session of Congress.

It supports a national health program consisting of national health insurance and Federal aid to States for public health, maternal, and child services, medical research and education, medical care for the indigent, and construction of hospitals and health centers. It opposes medical charity for the self-supporting, and restrictive laws preventing consumers, farmers, workers, and others from organizing health-insurance plans.

Senator SMITH. Did you say you were the Washington representative of the Committee for the Nation's Health?

Mr. LOUCHHEIM. Margaret I. Stein is the Washington representative. I am the executive director.

Senator SMITH. You may proceed.

Mr. LOUCHHEIM. The Committee for the Nation's Health is nonpartisan. It recognizes that sickness is no respecter of political affili-

l of bi-
em by
before
ogram.

y only
of di-
ho en-
ll con-
he Na-

cial se-
. You
r from
ship.
nedical
demon-
people
d who
esident

of this
e their
mittee.

Senator DONNELL. I assume it is all right for it to appear in the record immediately following your statement, as you request, but we certainly want to have the opportunity to cross-examine Mr. Davis on his statement.

Mr. LOUCHHEIM. He is here now.

Senator DONNELL. May I ask a question?

Senator SMITH. Yes, sir.

Senator DONNELL. I want to ask you if you know John B. Lawrence, who is an incorporator of Cooperative Health Federation.

Mr. LOUCHHEIM. I do not know if he is an incorporator of Cooperative Health Federation. I know a Dr. Lawrence who is assistant professor of medicine, Washington University, and medical director of the Health Institute of St. Louis.

Senator DONNELL. Now, this meeting of the board of directors that was held on May 9, 1947—where was that held?

Mr. LOUCHHEIM. In New York City.

Senator DONNELL. In New York City?

Mr. LOUCHHEIM. Yes, sir; at the Town Club.

Senator DONNELL. At the Town Club?

Mr. LOUCHHEIM. Yes, sir.

Senator DONNELL. Was Dr. Ernst P. Boas there?

Mr. LOUCHHEIM. Yes, sir; he was.

Senator DONNELL. Was Dr. Channing Frothingham there?

Mr. LOUCHHEIM. Yes, sir; he was.

Senator DONNELL. Is Dr. Frothingham still chairman of the committee for the Nation's health?

Mr. LOUCHHEIM. Yes, sir.

Senator DONNELL. And Joe Davidson?

Mr. LOUCHHEIM. Joe Davidson is not on our board of directors.

Senator DONNELL. Is he an honorary vice chairman now?

Mr. LOUCHHEIM. That's right.

Senator DONNELL. He was not present at that meeting in New York?

Mr. LOUCHHEIM. No, sir.

Senator DONNELL. In the paragraph of your statement beginning with the sentence—

> The purpose of the committee for the Nation's health, as indicated in its certificate of incorporation filed February 1946, is to promote and support legislation which will help make available good medical services to every person in the United States regardless of race, creed, color, or economic status—

then follows other language after that, and later on you say—

> Membership is limited to individuals who endorse the program just stated.

Do you mean by that that you will not accept as a member on your committee anyone who holds views different from the views that you have expressed here today? Is that your meaning?

Mr. LOUCHHEIM. I mean specifically, sir, what is expressed in the rest of the paragraph of which you just read the first sentence.

Senator MURRAY. What page is that on?

Mr. LOUCHHEIM. That is on page 2 of the statement, sir.

Senator DONNELL. Just what do you mean by this language on page 3:

> Membership is limited to individuals who endorse the program just stated, and who, through large or small contributions, make it possible for the committee to spearhead the Nation-wide effort to have health insurance enacted.

lth in-

surance
medical
of hos-
ng, and
organiz-

to be-
t must

ember
e prin-

like to
ed and
f dele-

Whereas voluntary sickness-insurance plans are rapidly gaining increasing acceptance by both physicians and potential patients and if extended and given either State or Federal financial aid and encouragement for persons of low income, where needed and properly and safely administered, will soon adequately meet the medical care needs of the Nation; and

Whereas the extension of any form of governmental compulsion into the personal affairs of the people is not in the American tradition and decidedly against the public interest; and

Whereas the AAPS is dedicated by the provisions of its organization to preserve and extend for all the people of America the superb record of medical care in the United States and to countenance only those changes which are in the public interest: Therefore be it

Resolved, That the house of delegates of the Association of American Physicians and Surgeons at its interim meeting held in Chicago, Ill., June 27 and 28, 1947, go on record as strongly disapproving the Wagner-Murray-Dingell bill and copies of this resolution be sent to members of the Senate Committee on Labor and Public Welfare, now holding hearings on the bill; and officers of the association be instructed to oppose vigorously the legislation by enlightening Members of Congress and the American public of the bill's many objectionable provisions.

House of Delegates of the Association
of American Physicians and Surgeons,
H. W. Detrick, M. D., *Speaker*.

Dr. Davis. Mr. Chairman and Senators, Mr. Louchheim has requested that the testimony which I have prepared and is now in your hands in the form of mimeographed copies, in accordance with the regulations, be copied into the record, instead of my reading it into the record, in the interest of saving time. I presume you have had an opportunity to study it, and I will summarize it and comment on it in order to expedite matters, if that is agreeable to you. Will it be satisfactory for me to proceed in that way?

Senator Smith. I have no objection, Dr. Davis, but I have not had time to read it yet. I had another committee meeting, so I didn't have time to read your statement. Is there any objection to proceeding in that manner?

Senator Donnell. No objection.

Senator Murray. In summarizing it, you will cover all the important parts of the statement, I presume. Is that correct?

Dr. Davis. I had in mind covering the most important parts in my summary.

Senator Smith. Go ahead. Your brief will be incorporated in the record, to follow your testimony.

STATEMENT OF MICHAEL M. DAVIS, PH. D., CHAIRMAN, COMMITTEE FOR THE NATION'S HEALTH

Dr. Davis. May I identify myself for the record as Michael M. Davis, a native of New York. I received a bachelor's and a doctor of philosophy degree from Columbia University and have been concerned throughout my professional life with the administration of hospital, clinic, and other health services and as a consultant concerning their economic and public relations. I appear here today as chairman of the executive committee of the Committee for the Nation's Health.

Senator Smith. That is the same committee that the previous witness referred to?

Dr. Davis. Yes. Mr. Louchheim is executive director of the committee.

Mr. Louchheim has already made clear the general position of the committee, namely, that we favor the National Health Insurance and

d S. 515.
h Insur-
bill from
rom the

nt and a
ustration
Rapids,
ient and
own how
between
onship to
nstances
a, which
n point I
ld work.
peration
nvolve a
e course
e doctors

follow-
peak. I

u're talk-

Carolina its quota from the national health insurance fund. North Carolina would have allotted the Halifax County health service area its quota.

Suppose Dr. Brown thought Tom Jones had pneumonia, that he had a poor heart and might be in danger. Tom Jones or his wife, if they were anxious, or Dr. Brown, if he thought it necessary, could call in a specialist, Dr. George Johnson, the one internist within reach. Either of these doctors might decide to ship Tom at once to the Roanoke Rapids Hospital, where he could get better care than Mrs. Jones could give him at home. The local health insurance fund would pay this hospital the costs of its services to Tom Jones.

In all this, neither Tom Jones, nor Dr. Brown, nor Dr. Johnson, nor the Roanoke Rapids Hospital would have anything to do with any official or board outside of Halifax County.

I think that summarizes the point pretty well. I then go on to explain how the relationship would be in case they called in a specialist, and how the qualifications of a specialist would be determined, and his right to receive payment at the higher rates which would be paid a specialist, as compared to a general practitioner.

Senator Donnell. Who would determine whether he is entitled to be considered a specialist?

Dr. Davis. The State agency administering the health insurance law would determine the lists of specialists—those in different branches who would be made eligible to receive payment as specialists. The national body—that is, the Board, the Federal Security Administrator, and the Federal Government, with the Advisory Council—would lay down the very general policy, such as, for instance, they would, as the law indicates, be required to recognize the standards set by the appropriate professional bodies.

Senator Donnell. Pardon me a minute, if you don't mind. Who would determine whether or not he is entitled to have a specialist?

Dr. Davis. Dr. Brown would determine whether or not he should call in a specialist.

Senator Donnell. Suppose Dr. Brown and the patient differ in their feeling as to whether or not a specialist should be called in? The patient thought it necessary; Dr. Brown thought it was not. Who would determine that?

Dr. Davis. Under those circumstances, the patient has a right to go to the nearest medical administrative officer available in that local service area, or in a neighboring one, and request, over the head of Dr. Brown, that he be allowed to have a specialist.

Senator Donnell. How large are these areas?

Dr. Davis. Under the law the States are required to make the necessary surveys and divide the State up into local health-service areas. The procedure there follows rather closely what is already in operation now under the Hospital Survey and Construction Act, which of course sets up, as you gentlemen know, a procedure for making such service areas and dividing the State up into those service areas.

Senator Donnell. I don't want to interrupt you, but I want to get these facts perfectly clear in my own mind. As I understood it, you said that if he and his physician, Dr. Brown, disagree as to whether Jones needs a specialist, Jones has the right then to go to an administrative officer; is that right?

Dr. Davis. A medical administrative officer.

in that

me near-

nsurance
number
istrative
by hav-
han one
ne if the

that he
nient to
pecialist
—is that
?

y I say
is treat-
e reason
o to one
ce Jones
him to
he right

want me to. The local health service organization of the area has a primary hearing on the complaint. If the complaint is one that involves a patient and a doctor, it is heard by a mixed group, such as a local committee—a mixed group of lay persons and doctors.

If, for instance, Dr. Jones was called in as a specialist, we'll say, over the head of Dr. Brown, and if he came to the conclusion that there had been gross negligence on the part of Dr. Brown, he might, on the basis of the desirability of not having Dr. Brown carry on because Dr. Jones regards him as incompetent, enter a complaint against him on the ground of pure negligence, and that complaint would be heard before a committee which would be composed wholly of physicians because it would involve questions of professional medical judgment, with a determination to be made as to whether there was evidence that such acts on the part of Dr. Brown revealed that he was professionally incompetent.

Senator Donnell. Dr. Davis, I would like to read this short excerpt from your prepared statement here. I take it this is correct:

> Suppose Mr. Jones was dissatisfied, and complained that Dr. Brown had delayed 24 hours making his first call and then was hasty and disagreeable. A local officer or committee would reach some decision about this complaint. Hearings and appeals could be had if demanded.

That is a correct statement, is it?

Dr. Davis. Yes.

Shall I proceed without further discussion of Tom Jones and the local area?

Senator Smith. Do you have any further questions, Senator Donnell?

Senator Donnell. I want to examine him further, but not at this point.

Senator Smith. Under the present system, if Mr. Jones didn't like Dr. Brown he would just give up Dr. Brown and call in Dr. Robinson; wouldn't he?

Dr. Davis. He can do that under this law, too.

Senator Smith. He can do that now?

Dr. Davis. He can do that now.

Senator Smith. Without this appeal proceeding?

Dr. Davis. Well, the appeal is only after there has been a complaint about the doctor. This statement about hearings and appeals relates to a complaint of misconduct on the part of a doctor.

Senator Smith. I am thinking of a man who has an appendix that is hurting him badly. He does not think that Dr. Brown is treating it quite right, and his wife goes to the phone and tells Dr. Brown, "You needn't bother to come over any more. We're going to Dr. Robinson and have him take care of it."

Dr. Davis. Yes.

Senator Smith. But Dr. Robinson has to be on the list or calendar of eligible doctors?

Dr. Davis. Yes.

Senator Donnell. But suppose his list is full and this patient's name is not on his list, the patient could not go to him; could he?

Dr. Davis. No. I take it you may wish to discuss that particular issue later.

Senator Donnell. Yes; later on.

discuss.
se of it.

descrip-
against
under it
w; that
e just a
racy. I

ves who
sensible
cal serv-
pattern
l varied

Federal
oes give
a stand-
e would

l terms.
ions, by
hat hos-

which ought to be vested in officers of Cabinet rank, as representing the President and the interests of the American people as a whole.

Senator DONNELL. Right at that point, may I read this one sentence from your prepared statement, at page 6:

> The Federal Security Administrator has the same authority over the Board that any Cabinet officer has over any one of his under secretaries or bureaus.

That is a correct statement, is it?

Dr. DAVIS. Yes, sir.

Senator DONNELL. All right.

Dr. DAVIS. I go on to speak about such broad oversight.

Senator DONNELL. Pardon me. You are referring now, I take it, to the language at the bottom of page 39 and the top of page 40 of the bill?

Dr. DAVIS. Yes; that is the determining language. There are some other points where the powers of the Federal Security Administrator are mentioned, but that is the general statement I refer to.

Senator DONNELL. Namely, if I may get it into the record that—

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator. The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

Is that correct?

Dr. DAVIS. Yes, sir. May I call your attention to something at that point, Senator?

Senator DONNELL. Yes.

Dr. DAVIS. In a determination of the regulations it is extremely important to bear in mind that the wording of this bill seems to give the Board the final word over regulations, and does not give the Federal Security Administrator any power to revise those regulations. I agree—and obviously I am not an expert on bill drafting—that there may be some difference of opinion about that, but I feel quite sure, as far as I can interpret this, that the Board has the final power over the content of the regulations.

The Federal Security Administrator's powers of supervision and direction are of a general character, but I do not think that he has the power to say, "This regulation you cannot make."

Senator DONNELL. You think even on that point there may be some room for argument as to the meaning of the bill in that respect, is that right?

Dr. DAVIS. Senator, there are many points in this bill—I want to say to you now that I have read this bill several times, but I am not in the position of saying or believing that this bill is perfect. In the first place it is complex. Obviously, it is long, and it is complex, and in the second place there are many questions in it on which there is reasonable ground for difference of opinion, not only between opponents and proponents of the bill, but among people who believe entirely and completely in the objective but who differ as to the best method of doing it.

In the third place it is not easy to draft wording which shall express just what you want to say, even if you agree on something—and I have argued many items in this bill with various other persons who

ho ought
s not one
whether
ning the

t the bill
or power
aking of
hong the

f the bill
extent to
ay go is

d like to
rs of the
that the
—that is,
delivery
o satisfy

istration
d provi-
n admin-
er States

Dr. DAVIS. I do not think that should be the intention of the bill, or is the intention of the bill. The point I would like to make on that is this: I think that any committee of Congress that is going into a bill of this kind, as far as the matter of wording is concerned, has to face a major decision in policy. Shall this be an independent agency in the Federal Government, under a Cabinet officer, responsible to the President, like the Federal Health Agency set up in S. 545, or shall it be within one of the existing departments such as is contemplated in this bill, or which roughly corresponds to it, or as contemplated in the report of Senator Aiken's committee in reporting a revised version of the reorganization bill, with which I am sure you are all familiar, which places a new Cabinet officer in charge of health, education, and social security?

It seems to me the basic policy decision is, Shall this be a separate agency? And if you accept that, then, gentlemen, Shall it be under a board? Then that board has final powers subject only to the general supervision that the President and Congress exercise.

Senator SMITH. I think that is a fundamental question, either way you approach it, either by the S. 545 or the S. 1320 approach, whether you want an umbrella over education, health, and welfare, or whether you want health as a separate unit. We have discussed that with a number of witnesses. I am glad to get your view on it. You think it ought to be under the umbrella over the three activities?

Dr. DAVIS. I do. I followed the hearings and attended some of them, and attended some in connection with Senator Aiken's bill.

Senator SMITH. About setting up a Cabinet officer with regard to the three?

Dr. DAVIS. Yes; and it is my own view that the advantages of interrelating health, education, and welfare, or social security, whatever you want to call it, under one officer, are very great indeed, because of the close relationship, especially between health and various forms of social security involving both self-supporting people and dependent people.

This bill, S. 1320, goes along with that general theory, as you see, in this present set-up.

Senator DONNELL. Reverting a moment to your prepared statement, I quote from page 6:

> S. 1320, however, gives to this Board a series of specified powers. The Federal Security Administrator has the same authority over the Board that any Cabinet officer has over any one of his Under Secretaries or bureaus.

Now, that is your construction of the meaning of S. 1320, is it not?

Dr. DAVIS. Yes, sir.

Senator DONNELL. Sir?

Dr. DAVIS. Yes; it is.

Senator DONNELL. Then, as you proceed you are not criticizing S. 1320 because the Federal Security Administrator does have the same authority over the Board as, you say, any Cabinet officer has over any one of his Under Secretaries or bureaus? You are not criticizing the bill on that ground, are you?

Dr. DAVIS. No. However, I wish to call attention to this point. I think those two sentences which you read have to be taken together. The second sentence compares the relation of the Federal Security Administrator to the Board with the relation of a Cabinet officer to

the first
l certain
s a Cabi-

that in
the bill
t is, the
hind the
l as the
specified
Federal
exercise
n would

Cabinet
uthority
nd make

they are

y of the
f Recla-
the head
he rules
conduct

Senator MURRAY. Define what that means then, will you please?

Dr. DAVIS. I have said before that that sentence which you read about the degree of authority corresponding to that of the authority of a Cabinet officer over one of his Under Secretaries or bureaus is limited by the preceding statement—that the preceding statement in the preceding sentence states that this law gives to the Board a series of specified powers. In other words, the powers of this Board, which corresponds to a bureau, are specified in the law in such a way that the administrator could not dictate the contents of the regulations.

Senator DONNELL. And yet again I quote the language from page 39 of the bill:

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

There is no exception. The word "all" is used. Would you comment on that?

Dr. DAVIS. No; there is no exception; that is true, but I do not see how one can take a single sentence like that outside of the context, and I take it that the interpretation of the law, both by administrators and by any reviewing committee of Congress in determining subsequent appropriations, is made in the light of common-sense regulations and governmental procedures well established elsewhere.

Senator DONNELL. I have no objection to taking it with the context. I have emphasized in this testimony the context as well as that sentence, and that is the statement which I read, and it seems to me that it states very clearly "All functions," and I ask that emphasis be placed on the word "all." "All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator." The word "under" means subordinate, too, does it not?

Dr. DAVIS. Yes.

Senator DONNELL. It is not my intention or desire to argue the point further, but that is the language, is it not?

Dr. DAVIS. Yes, sir; I would say that. I would also like to add there that if I felt that construction were the only possible construction, I should certainly feel it would be advisable to reconsider this wording in order to make the thing clear. That is, that general supervision rather than detailed direction is what is intended here, and if revision is necessary, I hope it will be made.

Senator MURRAY. In view of all your discussion and all the attention you have given to this thing, don't you believe that it should be made a little clearer?

Dr. DAVIS. I do, on this and several other points. As I said before, I think the bill could well be revised in order to clarify the intent, irrespective of the policies.

Now, if I may proceed, the next point that I make in my testimony moves from the question of one-man control to the issue of lay control, and I point out that almost all of our major institutions of medical services and medical education are under lay control. Practically all of our medical schools today are under boards of trustees composed entirely, or almost entirely, of nonmedical men. The control of voluntary hospitals is not in the hands of physicians but of laymen, usually lay boards of trustees. City, county, and State hospitals are likewise controlled by lay boards or officials. Not more than 5 percent of the

ntrolled
nishing

on page
of hos-
an Hos-
ples but
of our
of our

e might
vith the
in con-
atement

nistrator
nt to be,
interests
epresent-
l policies
t by the
t variety
er these

This principle justifies the establishment of an administrative board which may include a majority of laymen, as in S. 1320. It justifies the placing of the whole system under a Cabinet officer, who will represent the whole public rather than the interests of a profession. It also justifies two other important requirements of S. 1320: on the one side, that issues, complaints, and other matters wholly concerned with the technical questions of medicine shall be settled wholly by physicians; and on the other side, that advisory and administrative bodies, except those wholly confined to technical questions, shall contain a majority of public representatives.

Senator DONNELL. Do you advocate that the Federal Security Administrator be made a Cabinet officer?

Dr. DAVIS. I am in favor of the principle of the reorganization bill, as reported recently, which would make the Federal Security Administrator a Cabinet officer. I realize there are other ways of dealing with that problem, but that way seems to me to be the best way to do it.

Now I move on to another section of my testimony, which begins on page 9, relating to monopoly and the American Medical Association. The subject has been discussed in a number of other sessions by other witnesses, and I am not sure that you want me to read this section. If you wish to have me do so, I will summarize it.

Senator DONNELL. I would like to have you give it to us pretty thoroughly.

Senator MURRAY. It is an important point.

Senator DONNELL. I did not have an opportunity to read your statement, although you sent it in; and, speaking for myself, I would like to get your theory on this phase of it rather fully. I don't want you to abbreviate it to the point where it is difficult for us to get your views completely.

Dr. DAVIS. All right, sir.

At the present time, the American Medical Association and its State and county medical societies are insisting upon control of the health-insurance system by physicians. This demand is incorporated in the administrative section of S. 545, written, we are told, as a result of conference with representatives of organized medicine.

Senator DONNELL. Which section of S. 545 do you refer to?

Dr. DAVIS. That is the opening title I.

Senator DONNELL. You mean the National Health Agency?

Dr. DAVIS. Yes. Title I—National Health Agency.

Senator DONNELL. That is the administrative section to which you refer?

Dr. DAVIS. Yes.

Senator DONNELL. Thank you.

Dr. DAVIS. The same demand appears in the organization of the medical-care insurance plans sponsored by medical societies, and in some 20 States the medical societies have endeavored to enforce this demand by getting a State law which will guarantee them control, if not monopoly.

Senator DONNELL. Do you include Wisconsin as one of those?

Dr. DAVIS. What?

Senator DONNELL. Do you include Wisconsin as one of those 20 States? You recall that medical bill which has been referred to as a bill creating a monopoly.

create
r laws,
sconsin
re that
l there
ssed in
at the

hich in
v with

rstand-
passed

oes not
in any
ants to

ir Fed-
her by
ict and
slature

Ve had
ar Mr.

were told that they would be blocked by the insurance commissioner if they tried to set up their scheme in this way.

But the actual working of laws of the Wisconsin type, which exist in several other States, has been in effect to give the medical society power to create and enforce a monopoly. There are laws in some of the States, such as Illinois. I don't know whether this was discussed yesterday.

Senator Donnell. Yes.

Dr. Davis. Actually it does give the medical society, or requires that any medical-care insurance plan in Illinois must be in the control of physicians or that a majority of physicians be on the controlling body, nominated by the State medical society; so you do have control. And I imagine Mr. Hansen gave a report of the difficulties in Minnesota which the cooperative groups had found up there and the opposition of the State medical society there.

The point I am making is that the actual policy of State medical societies in many States, and this involves local medical societies also in the operation of those policies, has been such that they have endeavored to keep the principle that the control of health-insurance plans involving physicians' services shall be in the hands of physicians and shall be in the hands of physicians through a medical society.

Senator Smith. Is the motive for so doing mostly one of gain to control the business, or is the motive mostly with respect to the quality of service?

Dr. Davis. Well, Senator——

Senator Smith. Do you concede that the motive might be the rendering of top-quality service?

Dr. Davis. I would be glad to answer your question in this way: I think the mere motive of direct gain to the individual physician is a secondary motive. As Mr. Lasker said this morning, there is a business as well as a profession involved in the practice of medicine. Doctors have to make a living as well as serving mankind, and the business aspect has to influence policies, especially those of medical societies and groups of any kind, but I do not think that it is the primary motive.

There is a rather naive idea on the part of most physicians with respect to the conduct of an insurance program involving physicians' services, and the actual practice in medicine and the set-up and the history of the development of medical plans under medical societies, which have developed only in recent years, the earliest one going back to about 1939, have been such as to make it clear that that is the concept with which the medical society groups have approached it.

I had the occasion, Senator Smith, if I may say so—it happened by invitation—to sit with the committee of the New York State Medical Society at the time that they were getting their original plan, late in 1938 or early in 1939, underway. They asked me to come over there and sit with them. The president of the society was Dr. Carroll. I forget the names of most of the others I met with. And the one thing I said to them was:

> Gentlemen, I think that you are making a very great mistake to want to set it up in this way. If you seek control by physicians you are seeking control of the payments and disposition of the payments. You gentlemen, necessarily, being the physicians operating this plan and rendering service, are the chief recipients of the payments which come from the pockets of the subscribers.

nd tends
the sub-

nt that
control
ard of
al here
y time
e shall
I guess

ctice in
p plans
nething
setting
fakers
ou not,

fession
me that

Maybe
n that.
nd feel-

Dr. Davis. I would agree with you as regards the motives of the majority of the physicians. As far as their motives in these matters are involved, I would agree with you on that. On the other hand, I think I could cite, if there were time, which there isn't, a long series of examples where plans initiated or endeavored to be initiated by lay groups of people—industrial workers, farm groups, and so on, and sometimes by groups of physicians themselves in a group-practice unit—prepayment plans, have been bitterly fought both by local medical societies in the county in which the plan was situated, and by the State medical societies, in a way which indicates clearly that in the main the motivation on the part of a great many doctors was essentially a business motive, designed to prevent the competition of a type of enterprise or a practice clinic which they felt was something they did not want.

Senator Smith. We have some things, of course, which must be eliminated, as I stated to the witness who testified regarding certain things in Minnesota, but I want to get away from any general condemnation of the medical profession because some of these things may have been done. I want to correct any evils of that type as much as anyone in the world does.

Don't let me hold you up, Dr. Davis. I just wanted to put that thought in the record when you spoke of monopoly, and I want to make it perfectly clear that I do not feel that the evil significance of the word "monopoly" ought to be applied generally to the medical profession. I have never seen it personally, and I have had a good deal of experience with doctors.

Dr. Davis. I have included in my testimony, on page 10, a paragraph in which I have incorporated some sentences in which I endeavor to state my view. I have had long contact with many doctors in different parts of the country. I am well aware that the great majority of doctors are sincerely devoted to the service of their patients, but there is a business side to medicine, and as soon as you deal with the problem of any organized scheme, the business side tends to come into the foreground to a degree in which it does not come between the doctor and his individual patient.

Senator Smith. You make that charge against the Doctors' Hospital in New York, which was organized by doctors in the hope that it might be a reasonably profit-making enterprise, which it never was? The doctors were finding themselves obliged from time to time to put up their own money to meet the deficit, but nevertheless they carried on just the same, and that organization has done a wonderful job.

Dr. Davis. The majority of hospitals owned and run by doctors, and incorporated by doctors, have had a much harder time to keep going financially than have the other hospitals——

Senator Smith. Definitely.

Dr. Davis. Run as community enterprises.

Senator Smith. I agree with you. I have a brother-in-law connected with St. Luke's Hospital in New York. He is retired, and that is his life's work today. He is a pure layman, and knows no more about medicine than an ordinary man on the street. I agree with you that we need business management. I am getting at the motive behind the thing, so as not to leave the impression that at this nt any

be in-
search,

f some-
epends
or dis-

shown
stand-
stand-
true of
o their
have a
service
ndards

e with

page 10
society

Senator Donnell. You did not understand that the chairman of the board of trustees came in to testify other than with respect to the plans that had been put into effect by the medical profession, did you?

Dr. Davis. Well——

Senator Donnell. You did not think there was any concealment on his part that there were other plans?

Dr. Davis. I do not say there was any concealment on his part, but the plans were ignored in a pamphlet gotten out and distributed by the American Medical Association, and, as I will go on to say in a moment, have been ignored by the AMA in its recognition and discussions of medical-service plans in all the published reports I have seen on the council of medical service.

Senator Donnell. Do you have a copy of that 24-page pamphlet with you?

Dr. Davis. Not with me. I saw it the day of the hearing. It consists mostly of charts, with a rather brief text.

Senator Donnell. That was introduced in the hearing.

Dr. Davis. Yes.

Now, most of these 175 plans provide comprehensive medical service, that is, the services of general physicians and specialists in the patient's home and the doctor's office, as well as in the hospital.

Here we have it. The plans organized by medical societies offer only limited services, but the plans which have been organized by the people who pay the bills supply comprehensive care.

Why have not the plans organized by the people, the 175 plans, grown more rapidly in number and membership? The chief reason is that the State and county medical societies, with the support of the AMA, have put every possible obstacle in the way of prepayment medical plans except those run by medical societies. The medical societies have made it uncomfortable for doctors who joined such plans. Sometimes they have expelled doctors who joined them.

Furthermore, in about 20 States, the medical societies have recently caused laws to be passed which give special advantages to plans organized by medical societies and which, in some States, actually prevent any other plan from being organized. We have been over that part before.

Senator Smith. Of course I do not question the facts that you are stating here, but again I just want to note for the record that as I understand it, these medical groups have been trying to maintain standards and not let a fly-by-night organization grow up that does not meet those standards, and try to sell something to people that is not up to those standards. We want to consider that in this whole picture.

I do not agree with your statement that the plans organized by medical societies offer only limited services as compared with the other plans you speak of. We have had testimony here that they are trying to see, by experiment, trial and error, and by checking into various things, how much further they can go—the Blue Cross, the Blue Shield, and others—and now they are going into the whole field of how they can go into the house service as well. I don't think they are trying to limit their service, and I don't think the other plans have demonstrated that they have set up services that would give over-all coverage. I think it is a question of people who are experienced in the field of medicine trying to give the service in the group plan as rapidly

as been
pressed

loctors'

proach,
ich has
ty and
o start
d when
er than
That
call an

and I
that it
s coun-
cuse for
rtunity
ttempt
bstacles

success-
hen we
ups of

Dr. Davis. Yes; I would approve such a plan if it were well run.

Senator Smith. Doesn't the medical profession approve such plans?

Dr. Davis. In general. These plans—a large proportion of them—were started—well, some of them were, anyway—twenty or more years ago.

Senator Smith. I have heard about a lot of them. I have watched them with great interest.

Dr. Davis. But it has become increasingly difficult to start any such plans. Also, you recognize that the number of industries under such circumstances are either isolated, like an isolated mining company—take the Homestead Mining Co. in Utah, for example, where most of the people in the town where the company is located are employees of the company or the families of the employees; or a large corporation which has maybe two-thirds of the total population of the town and its environs either employed by them, or the families of those employed by them. Most of the companies which are in that situation, or a large proportion of them, got their plan started some time ago, before this issue became such that the medical societies became sensitized to the matter. A notable example along this line that I might point out is the Kaiser case, where Kaiser's industries mushroomed during the war. It was opposed very strongly, and had it not been for the fact that there was a war going on and the Kaiser industries had grown so rapidly and it was absolutely necessary that some sort of medical service were provided, I imagine the opposition to the plan would have been successful; but because of the fact that it happened during the war, the opposition was not effective.

Senator Smith. Why would there have been opposition to that? I am interested in your statement. I had not heard of any.

Dr. Davis. There are two reasons, Senator. In the first place, from the point of view of doctors—if I may interpret it from the point of view of doctors—there is a feeling of general antagonism to any change in the individual relationship between patient and doctor, and the feeling that if you change the method of payment you are going to change the personal relationship between doctor and patient.

The other factor is that the antagonism is purely on the business side, and they feel that these plans will be a form of competition. They will select a particular group of doctors who will be employed on a full-time or part-time salary, and the doctors not selected by the organization will be at a disadvantage, and there is some truth in this latter point.

It is a new form of organization. It is like the introduction of machine industry in competition with a hand industry—something of that order. And there is a competitive factor there which may be to the disadvantage of some physicians at a given time for a certain period, and one can sympathize with that in some instances and under some circumstances.

In many communities it would be reasonable, if one were doing this, to have a period of adjustment so as not to put doctors who have been practicing for years suddenly at a disadvantage with their patients by taking their patients away from them if they happen to be employees of the company, and they were not considered good enough to be taken on the staff of the plan.

I can see that side of it, too, but in the main I think the answer to the point that was raised is that it has become increasingly difficult to

me par-
y, and I
ans has
ll levels.

That is

y plans
onsored
se plans
dustrial
ng time
s of the
amilies.
n of the
the plan
rom the
agement
s. This
d indus-
nd hos-
al prac-

start socializing medical care we will find that only a step toward socializing the other parts of our economy.

Of course, people should pay for their medical care. Paying for what we need is always better than having things given us. What I point out, however, is that paying for medical care stands on a different basis from paying for food, shelter, clothing, or any of the other necessities and comforts in the budget of American families. Sickness costs are unpredictable as to when they will happen and how much they will be. You can plan your expenses or your food, rent, clothing, and every other commodity or service you buy, except one. That one is sickness costs. You cannot budget sickness costs in advance.

Therefore, there is good reason for putting the payment of sickness costs on a budgetable basis. That means an insurance basis. There is no such reason—in fact, it would be absurd—to advocate using the insurance principle for Mr. and Mrs. America's food or rent bills. There is, therefore, no justification whatever for suggesting that a widespread insurance system for medical care, either on a voluntary or a compulsory basis, furnishes a precedent for the rest of our economy.

But now comes another statement by Senator Taft. He says that national health insurance isn't insurance at all. He declares that a pay-roll deduction required by law is not an insurance premium but a tax. Of course it is a tax, from the legal standpoint. Any payment required of people by law is a tax. Nevertheless these pay-roll deductions, although they are a tax, are also insurance. They are insurance because they enable the people who pay them to protect themselves against an unpredictable risk. An individual alone cannot protect himself against such a risk, but large groups of people can do so. Spreading a risk among a large group of people and over a period of time is the essential characteristic of insurance, irrespective of the method or auspices through which this principle is applied.

Now I move on to another subject: Health insurance abroad.

Compulsory health insurance is attacked on the ground that it has been "a failure in foreign countries." The usual technique of this attack has been to repeat a series of misstatements over and over again, despite the fact that their inaccuracy has been demonstrated over and over again. Time permits only a few examples.

One common misstatement concerns administrative costs. To quote: "In the experience of Europe there would be an employee of the system outside the field of medical service for at least every 100 persons insured." From this statement, simple arithmetic leads to the conclusion that a great deal of the money paid by the people for health insurance would go to fatten government bureaucrats. A sixth grader can calculate that there would have to be a million payrollers if 100,000,000 Americans were insured.

The figure of 1 administrative employee per 100 insured persons is a gross untruth. Last year, Dr. Frank Goldman, associate professor of public health in that hive of intellectual rectitude, Yale University, and an internationally recognized authority on this subject, testified that in the well-established European systems the number of administrative employees is about 1 to every 2,000 persons.

Senator SMITH. Might I interrupt there to say that as a Princeton man I am highly interested in your statement that Yale University is a hive of intellectual rectitude. I am very glad to see you en-

e of the
ation of

on. We

100 per-
rance in
He was
society

s report
ns man,
the fig-
ersation
ed some

hat that

eing, of
l effort
uld talk

they were concerned with the administration of all of the various forms of social insurance which were accepted by law in Germany, and that included old-age insurance, invalid insurance, unemployment insurance, and so on, as well as health insurance.

Senator DONNELL. According to the name of it, it would indicate that it had to do with health insurance, would it not?

Dr. DAVIS. The building that he visited was not a building devoted only to health insurance; it was the central office, the administrative office, of the Krankenkassen. Not only was the Krankenkassen there, but included therein was the entire administration of social insurance.

I might say that the administration of the Krankenkassen is not run by the Government. They merely have to comply with requirements set down by the law, but they are not run by the Government.

To illustrate that, a prominent official of the Metropolitan Life Insurance Co., now dead, who went abroad on a trip to study the German system, came back and said:

> I should say that the amount of supervision exercised over the German Krankenkassen by the German Government is somewhat less than that exercised by the State department of insurance in New York over the Metropolitan Life Insurance Co.

I just wanted to point that out to you gentlemen.

Now, Mr. Crownhart made another mistake. He had forgotten or he had not looked into the details enough to know that when he got his figures covering the insured persons in Germany they gave him the number of insured persons, but insured persons meant the workers who were insured, the amount of their payments, and the scope of the law provided service for their dependents, their wives and immediate dependents, as well as for themselves. Consequently, in getting the ratio between the number of employees and the number of persons insured, he had made the mistake of counting in employees who were dealing with other things besides health insurance; and he also made the mistake of assuming that only insured persons, instead of also the members of their families, which averaged about two and one-half persons per employee, were included in those figures.

As far as I could judge in talking to him, those were the mistakes he made.

Senator DONNELL. Did you mention those mistakes to Mr. Crownhart and get his answer to your conclusions?

Dr. DAVIS. Well, in my conversation with him a good many other things were discussed. He had visited a number of countries, some of which I had visited too, and he had been to some of the places that I also had been to, so that there were a good many other things on which I felt it necessary to be critical. His report had then been prepared and finished. I criticized his report on this and on a number of other grounds in my conversation with him. However, it was then too late to change it.

Senator DONNELL. Did you call to his attention these two mistakes which you thought existed?

Dr. DAVIS. Yes; I did.

Senator DONNELL. What did he say in response to your suggestion that those two mistakes had caused him to err?

Dr. DAVIS. It is a little difficult for me to remember exactly our conversation. It took place back toward the end of 1938 or the beginning of 1939, nearly 10 years ago, and I can't remember now just what

ved the
position
e sound.
he ratio
ssion he
he had

of 1 to
to 1,000
r which
e simply
laries to
00 would
to 1,000

nsidera-
mean an
e. Else-
ninistra-
ne figure
only sal-

es to be-
t, but it

Dr. Davis. I should expect so. It would vary with the number of employed persons earning above the amount specified in the bill.

Senator Donnell. If we have 140,000,000 people in the country, that would be—let's see—that would be about 119,000,000 people who were insured—say 120,000,000 of our 140,000,000 population.

Suppose you take Dr. Goldman's figure of the number of administrative employees, of about 1 to every 2,000 persons. That would mean, according to my hasty figures here, about 60,000 employees, based on Dr. Goldman's figure, is that correct?

Dr. Davis. Yes.

Senator Donnell. Do you think the plan that you are supporting, S. 1320, would necessitate the employment of 60,000 administrative employees? Is that right?

Dr. Davis. Well, yes. I would think so. However, I would say this: In considering the number of new administrative employees, you would have to consider to what extent people already engaged in hospitals and other forms of public welfare administration involving medical services—to what extent the existing organizations and their administrators would be used. There would be some cut down. It is actually very difficult to estimate until you have made State by State surveys, such as are contemplated under this bill.

It is difficult for one to make a statement along that line, except that I think the figure would be in the order of the one you mentioned, rather than in the order of 5 or 10 times that many.

Senator Donnell. Mr. Crownhart's figure would make it 20 times that, would it not?

Dr. Davis. Yes, sir.

Senator Donnell. Which would be 1,200,000 employees, is that correct?

Dr. Davis. Yes.

Senator Donnell. That is right, is it not?

Dr. Davis. Yes.

Senator Donnell. In other words your judgment as to the number of administrative employees that would be required in a plan of this sort, as I take it, in round numbers is based on Dr. Goldman's figures, which means that it would require 60,000 administrative employees to administer S. 1320. Mr. Crownhart's figures would increase that number to 1,200,000 such employees. And you state that you think Mr. Crownhart erred because of the two mistakes that you think he had made, and that you called those two mistakes to Mr. Crownhart's attention, and he still persisted in the view that his figures were approximately correct. Is that a true statement of your testimony, Dr. Davis?

Dr. Davis. Yes.

Senator Donnell. Thank you.

Dr. Davis. I would also say this. I do not think that we could administer health insurance on a Nation-wide scale under this bill as cheaply as most of the European countries have, for two reasons. One, most of them have developed local organizations already established on a cooperative or industrial basis of some kind involving the workers themselves, which can be utilized and which already have been utilized.

The second factor is that we have a much larger proportion of sparsely settled areas than the European countries have, and you can-

popu
tion.
ve cost,
nd cer-
at as a
to this
ong the

fed, ap-

ees over-
that we

in the
ruman's

al word
spapers
in con-
ough a
al pub-

That's
lt with

claim sends out material to a list of several thousand newspapers and periodicals.

Senator SMITH. I think that the so-called propaganda, frankly, has gone both ways. It has gone to prove the position you are taking. I have seen masses of it. I saw it in the PAC publications 3 or 4 years ago, when they started it up. I am not criticizing it. I think both sides try to show what they think it is going to cost us and what the expenses would be. It is reasonable to expect proponents on both sides will try to get their information out. That is the way we do things in America. It may not be the best way, but that is the way we do it, and I am not prepared to criticize one side more than the other in this controversy, for doing what both have a right to do. You have done a noble job in the advocacy of your cause, Dr. Davis. I have heard from you many times, and I have complimented you many times on the ability with which you have gotten your ideas across to the public. You ought not criticize your opponents for using exactly the same methods.

Dr. DAVIS. I appreciate what you have said, Senator, and I only wish to say this. I do feel—although I don't think this is particularly germane to the testimony—but I do feel that many of the items released by the National Physicians Committee—many of the so-called facts—are less than factual.

Senator SMITH. Just the facts?

Dr. DAVIS. Yes; but I also feel that I must make one other statement, and that is that I cannot help but feel a little envious of an organization that is able to spend per month—or was doing so, according to its reports as a lobbying organization over the last 6 or 7 months of the year—slightly more than the Committee for the Nation's Health was able to raise in the whole year. So a certain amount of envy crops up inside of me when I think of how much more we could have done if we had had 12 times as much money.

Senator SMITH. You have had splendid support from labor organizations, and so forth. The work has been very well organized. You have had good publicity. And in presenting your point of view, whether we agree with it or not, we compliment the ability of those who are able to get it out and circulate it. Let's not call those on the other side of the fence names, when we live in a glass house ourselves.

Dr. DAVIS. I hope at least my expression of envy will be regarded as pardonable.

Senator SMITH. It is.

Dr. DAVIS. Those who charge that there is organized propaganda in favor of national health insurance must admit that these identical attacking editorials suggest that somebody has organized propaganda on the other side. Who supports the writer whose brain child is multiplied thus in the free press of America? I do not know. I do know that the National Physicians Committee states that they have a public-relations staff which sends out material to a list of several thousand newspapers and periodicals. So maybe these editorials merely prove that the National Physicians Committee finds a market for some of its canned goods.

Health insurance in foreign countries is charged with a long list of other evils—poor quality of medical care, for instance, and promoting an increase of sickness. Some of these charges are based on

stories
l cases.
d over
y their
news-
and, of
ill ever

-inten-
n New
used.
mes or

ir.

blished

-inten-
n New

nerally
ou give
is that

I will give one illustration of the main point. The main point of the article was that the abuses which had developed by 1945, since the New Zealand system had been established, particularly the increase in costs and the number of doctors—apparently a small proportion but a distinctive number—who were earning very large incomes and taking more patients than they could properly treat—that these abuses had reached such a point that the system would have to be scrapped, according to the article written by this correspondent.

As I said, I also wrote to the Minister of Health at the same time that I wrote to Dr. Robb in New Zealand, and he wrote back to say, commenting briefly on the article, that the article had some correct facts in it about the abuses, but the main effect of the article was to give a completely incorrect impression, because while it was the intention of the government which he represented to take steps to correct any existing abuses, the government had no intention of scrapping the system at all. They were going to take steps to control the system, and they hoped to have the cooperation of the New Zealand Health Association in connection with that control. However, as I stated, those two articles were widely publicized.

Senator DONNELL. To your knowledge, Dr. Davis, is it contemplated in New Zealand that they shall take the administration of this law off of a fee for service basis and put it on a per capita basis?

Dr. DAVIS. I cannot answer that question, Senator. I do not think that that question has been answered in the sense that they have reached a conclusion as to how to do it.

I would say this: The information that I have—the most recent information that I have on that—is from Dr. Douglas Robb again, and it is to the effect that he thinks the discussions which are in progress between the Government and the representatives of the organized physicians of the New Zealand Medical Association are in the direction of endeavoring to control the abuses under the fee for service system for general practitioners. The system of paying for specialists involves somewhat other factors, and the likelihood is that the payment for specialists may be put very largely on a salary basis.

Senator DONNELL. Mr. Chairman, might I interrupt at this point for a moment to offer at this time for the record, with the request that it appear immediately following Mr. Davis' testimony along this line, an article appearing in the Christian Science Monitor of April 12, 1947, entitled "Compulsory Health Insurance Costs Soar in New Zealand" with the caption under the headline "Special to the Christian Science Monitor," and with the location given as Wellington, New Zealand. I understand the article came from there.

Senator SMITH. Do you have the date on that?

Senator DONNELL. Yes, sir—April 12, 1947—I request that this be incorporated in the record.

(The article referred to follows:)

[From the Christian Science Monitor, Boston, Mass., April 12, 1947]

COMPULSORY HEALTH INSURANCE COSTS SOAR IN NEW ZEALAND

(Special to the Christian Science Monitor)

WELLINGTON, NEW ZEALAND.—Continually rising costs have marked 8 years of compulsory health insurance in New Zealand. Deep concern is felt by many New Zealanders over the high cost trend of the system.

In these
hich they

e general
eavy day,
on but to
n may be
icult case

one is in
an is not
e persons

ong wait
nd under-
ne, as the
accommo-

centuated
omes; but
taxation,

ublic, the
can quote
t of some

5,500,000,
hospital,

That the scheme has gone wrong somewhere is becoming more and more evident. As an alternative, the medical profession proposes a revision of the scheme to lighten the cost, but with a continuance of maternity benefits and other expensive items. They also propose that each citizen should pay directly for treatment of minor ailments, unless he is genuinely unable to do so. In the opinion of the medical profession this would help clear away the deadwood of triviality that makes up so much of a physician's working day at present.

Senator DONNELL. I also ask that there be incorporated in the record a letter dated June 30, 1947, addressed to "Miss Marjorie Shearon, Ph. D., Committee on Labor and Public Welfare, United States Senate", from Dr. J. P. S. Jamieson, of Nelson, New Zealand, the concluding two sentences of which read as follows:

The free general medical service or general practitioner's service, designed to replace the private family doctor by State doctors, is in a chaotic condition and had better be shunned. Free specialist service has not been undertaken yet. I will amplify later.

Yours faithfully,

J. P. S. JAMIESON.

I ask that this letter also be incorporated in the record.

(The letter referred to follows:)

NELSON, NEW ZEALAND, *June 30, 1947.*

Miss MARJORIE SHEARON, Ph. D.
Committee on Labor and Public Welfare,
United States Senate.

DEAR MISS SHEARON: I have your letter of June 19, 1947, regarding the social security medical services of New Zealand. It will take a little time to assemble what information I can offer, and your letter was received today. In about a week I will forward what I can. In the meantime, I can say that certain parts of the general scheme are proving beneficial, while other parts are having a seriously detrimental effect upon the practice of medicine. It would therefore be unwise to accept the New Zealand system in toto as a pattern to be followed.

The free maternity service, diagnostic X-ray service, and laboratory service are, in my opinion, all to the good—beneficial to the people, and help to the practitioners. Free hospital service has more good in it than bad; but it is as yet working imperfectly. The free general medical service or general-practitioner service, designed to replace the private family doctor by state doctors, is in a chaotic condition and had better be shunned. Free specialist service has not been undertaken yet. I will amplify later.

Yours faithfully,

J. P. S. JAMIESON, M. D.

Dr. DAVIS. May I add this word at this point. I had some contact with Dr. Jamieson almost 2 years ago. Dr. Jamieson has been one of the active representatives of the New Zealand Medical Association, and his general point of view was very strongly opposed to the scheme which the Government, a labor government, has been developing ever since.

Senator DONNELL. He is a man of high standing, is he not?

Dr. DAVIS. Oh, yes. Well, I assume a physician occupying a position of importance in a medical association usually is a man of high professional standing. I know nothing more about him except that he occupies such a position.

Shall I proceed?

Senator SMITH. Yes.

Dr. DAVIS. Last month the Woman's Home Companion published an article scareheading unnecessary operations by American surgeons. This article and the full-page newspaper advertisements about it have been read by millions, but does anyone take it as representing

article
emedy.
litorial
. That
ess evi-

is that
of all
in the
ervices
untries

tional-
for 16
ittee of
nedical
nedical
w this,

ed the
ld soon
lid not
in the
if the
a one-

I want now to come back to our own land and to conclude with some remarks about costs. The medical propaganda machine——

Senator DONNELL. Pardon the interruption, Dr. Davis. By the way, I refer to you as Doctor, but I understand you are not a physician.

Dr. DAVIS. I am not a physician.

Senator DONNELL. You are a doctor of philosophy, is that correct?

Dr. DAVIS. That is correct.

Senator DONNELL. Do you know just who it was who prepared the report that was published last March by the United States Public Health Service?

Dr. DAVIS. I'm sorry. I do not.

Senator DONNELL. At this point I offer for the record an article appearing in the Christian Science Monitor of January 4, 1947, by A. M. Simons, formerly assistant director of the bureau of medical economics of the American Medical Association, and coauthor of The Way of Health Insurance, an article entitled "Hiatus in Sickness Insurance," further headed "Favorable evidence or praise found lacking in areas where system is adopted."

I ask that that be placed in the record.

Senator SMITH. So ordered.

(The article referred to follows:)

[Reprint from the Christian Science Monitor, January 4, 1947]

HIATUS IN SICKNESS INSURANCE—FAVORABLE EVIDENCE OR PRAISE FOUND LACKING IN AREAS WHERE SYSTEM IS ADOPTED

(By A. M. Simons)

> A. M. Simons was formerly assistant director of the bureau of medical economics of the American Medical Association and is coauthor of the Way of Health Insurance, written after personal investigation in Europe.

There is one big hiatus in the testimony presented to the recent congressional committee investigating compulsory sickness insurance and in all the mass of arguments offered by its proponents in the press and over the radio.

Although we are told over and over that more than 30 nations now have such systems, no favorable evidence drawn from the working of such systems is ever presented. No unprejudiced visitor returns from any of these systems with praise for its operation or vital statistics of its accomplishments in improving the health of the people insured.

Reports of the British health organizations are never quoted to show the medical service has been improved.

Germany has been prolific in statistics of the operation of compulsory insurance, but none of the data ever claim to show that sickness has grown less, or that absence from work due to sickness has declined during more than half a century of insurance.

If these reports were ever presented, they would show a continuous increase in sickness during the life of these systems.

Many statements are available from the vital statistics of these and other countries under insurance showing that the combination of cash payment for a sickness which must be treated without cost to the patient if he is to be paid the cash removes the will to get well.

Statistics of the Leipzig Krankencassen, the largest sickness-insurance society in the world, evidence that the average day's sickness per member annually increased from 10.01 in 1887 to 1905 to 19.35 in 1928 to 1930. Similar increases under compulsory systems in Britain, Austria, and other nations testify that this increase is due to the existence of compulsory insurance and not to any national peculiarities.

This conclusion is further confirmed when such nations as the United States, Australia, and Canada, without insurance, have shown an opposite trend.

nsurance
society to
ious lack
nich they

*

e highest
d surplus

mpulsory
but he is
ount with
ssion and

ot due in
sickness,
penditure

that it is
l for, and

s reveals
—a confi-
whom he
le to the
for cash
asked for
declared
the third

systems like that proposed here, any examination of the existing systems would show a mass of heated discussion of this problem.

But no solution can receive much consideration while political and economic causes of sickness dominate the situation. Politicians know, though they are reluctant to admit it, that the real attraction of sickness insurance is the cash payments and not the medical care, and they adjust their attitudes to fit that fact.

Senator MURRAY. Dr. Davis, you say you do not have a copy of that report of last March with you?

Dr. DAVIS. I'm sorry, I do not. I meant to bring it with me. It was published in one of the Public Health Reports, which is the weekly publication of the United States Public Health Service, and I should say approximately that it appeared during one of the weeks during the month of February.

Senator MURRAY. Could you furnish the committee with a copy of that report, so that it may be incorporated in the record?

Senator SMITH. That report will be included in the record, Dr. Davis, if you will give us a copy.

Dr. DAVIS. Yes; I will have my secretary get it for you.

Senator SMITH. You will send it to the secretary of the committee, so it will go right in the record?

Dr. DAVIS. All right, sir.

Shall I proceed?

Senator SMITH. Yes.

(Subsequently Dr. Davis submitted the report referred to as follows:)

[From Public Health Reports, Vol. 62, No. 11, March 14, 1947]

Printed With the Approval of the Bureau of the Budget as Required by Rule 42 of the Joint Committee on Printing

HEALTH INSURANCE PROGRAMS AND PLANS OF WESTERN EUROPE

A SUMMARY OF OBSERVATIONS [1]

By JOSEPH W. MOUNTIN, *Medical Director, United States Public Health Service*, and GEORGE ST. J. PERROTT, *Chief, Division of Public Health Methods, United States Public Health Service*

Among the most conspicuous aspects of postwar reconstruction in Western Europe are the attempts to establish broad social security programs with particular emphasis on health security. Data recently gathered from personal interviews and documents collected in England, France, Belgium, Sweden, Denmark, and the Netherlands reveal the scope and direction of the changes effected or proposed in these countries during or shortly after the war. In all these countries, legislation has been enacted to increase the protection afforded against risks of income loss from sickness, maternity, and permanent disability and to remove or reduce the financial obstacles to preventive, diagnostic, and therapeutic medical care.

All six countries visited—even Sweden which was not an active participant in World War II—have emerged from experiences that severely tested the strength of their social, political, and economic institutions. Yet far from losing faith in their social insurance programs, the people of these countries have united in efforts to expand these programs or other provisions for health security or both.

The two countries (England and Sweden) that escaped invasion and occupation by the German army have formulated comprehensive programs for health and medical care and have discarded all the income and occupational restric-

---

[1] From the Divisions of States Relations and Public Health Methods.

The authors gratefully acknowledge the services of E. B. Kovar, Martha D. Ring, and Arthur Weissman in selecting, summarizing, and collating data.

Beveridge
d, before
financing
nomalous
, Sweden
universal
uld make
ers.
nds) face
city, and
morale of
t less ex-
the broad
es, which

urity pro-
ic health,
and the
e of medi-
phasis.
social in-
ring tem-
six coun-
olly alike
artime or
as or pat-

e systems
they met
pt in the
stem and

principle. Three countries (England, Denmark, and the Netherlands) use a capitation basis for paying general practitioners under the health insurance system, though new provisions in England leave the way open for a supplementary salary, and in Denmark fees for service are a common alternative to capitation payments. Three countries (France, Belgium, and Sweden) use the fee-for-service method of remunerating general practitioners, though Belgium has an additional provision for capitation, and in Sweden some salaried public doctors get fees for serving insured as well as other patients. No specific pattern for paying specialists appears predominant, except that the fee-for-service system is common when specialist care is not included as part of the hospital benefit.

7. The new laws or existing programs of four countries (all but France and the Netherlands) provide that public funds shall meet all or most costs of expensive illness requiring hospitalization and the services of surgeons and other specialists, removing nearly all financial barriers for these forms of medical benefits. Three of the countries (France, Belgium, and Sweden) require that insured persons bear some part of the costs of general practitioner's services and medicines, by providing reimbursement for only part (two-thirds or three-fourths in Belgium, three-fourths in Sweden's new program, and four-fifths in France) of the fees for service set forth in an approved fee schedule.

8. When an insured person receiving cash sickness benefits has a dependent wife and children, allowances for these dependents are, or will be, payable in three countries (England, France, and Sweden). The benefits payable for illness are, or will be, virtually unlimited in duration in all countries, either by assimilation with disability benefits (England), or by transfer to invalidity pensions (all but England) and subsequent transfer to old-age pensions. Public funds contribute toward cash sickness benefits in all but two countries (France and the Netherlands).

9. In all six countries, medical benefits for insured persons and their dependents, provided or proposed, include most essential services and supplies, though in all countries the existing or recently authorized programs face questions of numbers and distribution of personnel and facilities necessary to meet their health objectives.

10. All six countries are approaching their health-insurance programs with due allowance for the need to work out step by step administrative and other details of health-security programs in cooperation with the professional and technical personnel concerned and the persons covered by these programs. All recognize that success will depend on that cooperation and on the extent to which national income and productive capacity can be maintained at or raised to adequate levels.

11. In all six countries, medical practitioners and others concerned with health security problems agree, in general, on the value of insurance devices and the use of public revenues to finance medical-care programs. The differences of opinion voiced on the need for expanding these programs relate to the details of operation, the income level of the population to be covered, and the rates and methods of remunerating practitioners.

12. Either in conjunction with health insurance or as separate health security programs, all six countries propose to expand tax-supported services for maternity care; child health and welfare; dental care; early case finding and treatment of chronic conditions and tuberculosis, venereal, and other communicable diseases; immunization and vaccination; medical care of assistance recipients and old-age and invalidity pensioners; care of convalescents; and hospitalization. All are working out hospital plans to group small local units around central well-equipped establishments, so that persons in all parts of the country may have relatively prompt access to the most advanced techniques in the diagnosis and treatment of illness. These programs are cited in the following summaries only insofar as they throw light on the types of medical and maternity services proposed or provided in the health-insurance system.

England and Wales

Compulsory health insurance was inaugurated on July 15, 1912, under the provisions of the National Insurance Act of 1911. From 1919 to 1941, amending legislation increased benefits, coverage, and contributions. During 1944, 1945, and 1946, basic recommendations in the PEP (Political and Economic Planning) report of 1937, the Beveridge report of 1942, the reports issued by the Nuffield Provincial Hospitals Trust in 1945 and 1946, and in other studies were enacted into law.

The National Insurance Act of 1944 provides, among other things, for the transfer of all national health insurance functions, except the administration of medical benefits, from the Ministry of Health to the Ministry of National Insur-

g illness;
; unem-
compen-
National
ndustrial
nder the
rporated
ayments
evels for

compre-
m, which
types of
day the
ssent, a

and and
es some
loyment,
n supple-
s income
l distrib-
children
ng child
ing, and
ss of in-
nsurance
tries re-

by the

payments are made. The fund will be made up of contributions of insured persons and employers and of supplemental Exchequer contributions and grants. From these contributions, amounts ranging from 6d. (10c) to 10d. (17c) per insured person will be alloted to the National Health Service, even though medical services are to be provided irrespective of insured status—on the theory that the medical service will result in savings to the fund in expenditures for cash sickness benefits. The source of all funds for the National Health Service and the annual amounts estimated to be needed during the early years of operation are (4, p. iv):

Source	Amount, in pounds sterling	Percent of total
Total	152,000,000	100
National Insurance Fund	32,000,000	21
Local authorities	10,000,000	7
Exchequer (net amount)	110,000,000	72

Annual expenditures for health services during the early years of operation are estimated as (*4*, p. iii):

Type of expenditure	Amount, in pounds sterling	Percent of total
Total	152,000,000	100
Hospital and specialist services	87,000,000	57
General practitioner, pharmaceutical, dental, and other services [1]	53,000,000	35
Local health authorities' services	12,000,000	8

[1] Includes superannuation and special compensation for medical and dental practitioners.

Single weekly contributions, varying with age, sex, source of income—and for employed persons, with rate of remuneration—will be paid for all cash sickness and invalidity, unemployment, maternity, survivors', and old-age benefits. For employees, the initial weekly rates will range from 2s. 2d. for girls under age 18 to 4s. 7d. for men aged 18–70 who earn more than 30s. a week; the weekly contributions of employers for their employees will range from 1s. 9d. to 5s. 9d. The range for self-employed persons will be from 3s. 1d. for girls under age 18 to 6s. 2d. for men aged 18–70, and for persons who are not gainful workers, from 2s. 3d. to 4s. 8d. These weekly contributions will be paid, as at present, by affixing insurance stamps to contribution cards. The Exchequer supplement will range from 4d. per week for girls to 1s. 1d. for adult males.

Until the new laws are in operation, health insurance contributions remain separate from those for the other social insurance programs and for insured persons, with certain exceptions, range from 2d. a week for juveniles to 5½d. for employed men aged 16–65; in general, the employers' contributions equal those of their insured employees, and the Government supplements the health insurance funds by periodic grants. In 1944, approximate receipts for national health insurance totaled £51,093,000. Of this amount, £34,821,000 represented contributions by employers and employees; £9,867,000 consisted of Parliamentary grants, and interest and miscellaneous receipts accounted for £6,405,000.

Regulations on remuneration of practitioners under the National Health Service Act of 1946 have not yet been promulgated, and agreements have not as yet been made between practitioners and the committee provided for in the act. It is believed, however, that capitation will be the basic method of payment. As under the existing program, patients will have the right to choose their doctor, and doctors will be free to accept or reject any persons who ask to be placed on their panels. Regulations may limit the number of patients on a doctor's list, and provision is made for limiting the number of practitioners in an area. Any physician whose name is entered on any list for the provision of medical care on the day the act becomes effective will be entitled to compensation (payable at retirement, death, or other specified time) for any loss suffered through inability to sell his practice, since the act prohibits such sale.

uarterly
certain
eir own
doctor's

he cash
payable,
age and
kly rate

eekly rate
42s.
26s.
16s.
16s.
16s.
[1]7s 6d.

ess than
tion can
rmanent

tantially

t rate
sablement
10s. 6d.
9s.
8s.

ave been

additional benefits (including dental, ophthalmic, convalescent home care, surgical appliances, etc.) have been permitted, however, for approved societies with appreciable surpluses at quinquennial valuations of their funds. Thus, the amount and type of additional benefits have varied according to the financial status of the society in which the insured person was a member. Likewise, no provision has hitherto been made for hospitalization or for specialists' services for insured persons, except as additional benefits from approved societies with adequate financial reserves.

France

When the war broke out in 1939, France had social security laws providing workmen's compensation; old-age, invalidity, and survivors' pensions; cash and medical benefits for sickness; death benefits; and maternity insurance, including special allowances for nursing mothers and a system of milk vouchers for other mothers. Compulsory cash sickness benefit and medical care insurance was first established, in 1930, under a law enacted in 1928 providing, in addition, for maternity, invalidity, survivors', and death benefits. The law of 1928 was administered largely by approved mutual benefit societies, which established separate local and regional funds for each type of insurance benefit; these funds collected the contributions and distributed the benefits fixed by law.

Although some changes were made in this system of social insurance by the Pétain government during the German occupation, it continued to operate in substantially the same form until the liberation of France in 1944. Soon after liberation, laws were passed setting up a more comprehensive system of social security. The new legislation also provided extended coverage, increased benefits, and a new administrative structure for the social security system. The two major statutes which accomplished these changes were the Ordinance of October 4, 1945, establishing a new system to finance and to administer social insurance benefits, old-age grants, compensation for industrial accidents and occupational diseases, family allowances, and single-wage allowances (special payments to families in which there is only one wage earner), and the Ordinance of October 19, 1945, organizing a new social insurance system for persons employed in nonagricultural occupations covering sickness, maternity, invalidity, old-age, and death benefits. Most of the provisions of both laws went into effect on July 1, 1946.

Further extension of social insurance to cover virtually the entire French population was provided for in a law passed on May 22, 1946; it was stated in the text of the law, however, that most of its provisions were not to come into force until the French industrial production index had reached 125 percent of that of 1938. In September 1946, this index was about 70 percent of 1938.

Administration.—Health insurance, including benefits during sickness, maternity, and invalidity, is administered in France through a system of local and regional bodies called social security funds. The insurance system is based wholly on contributions from insured individuals and their employers. Government participation is limited to exercise of technical and financial supervision.

The functon of local bodies, or primary funds, in the administration of health insurance is to award cash and medical benefits for sickness, maternity, and death benefits. In the local administration of health insurance, the primary funds supersede the formerly approved mutual benefit societies. Primary funds, set up on a provincial (départementale) basis, are governed by administrative councils on which two-thirds of the seats must be held by representatives of insured persons. The remaining third of each primary council's membership must represent employers, family associations,[3] and professional social security experts. Depending on the number of members in a specific fund, its council has either 12, 24, or 36 members. Primary funds must create local sections for each group of at least 2,000 insured persons. In large cities, in addition to ordinary primary funds with 12- or 24-member councils, a central primary fund is established with 36 or 48 members on its administrative council. Two doctors are attached to primary fund councils in an advisory capacity.[4]

---

[3] An Ordinance of March 3, 1945, promulgated by the Ministry of Population, gives family associations new legal status; they are defined as groups created for the moral and material protection of the general interests of families.

[4] More recent information indicates some changes in composition and methods of selecting administrative councils of social security funds; higher maximums for cash sickness, maternity, and invalidity benefits; and an increase in the maximum wage on which insurance contributions for nonagricultural workers are based (Secrétariat d'Etat à la Présidence du Conseil et à l'Information, Direction de la Documentation: La Sécurité Sociale en France, Première Partie: Notes Documentaires et Études, No. 451; October 25, 1946.)

minister
or equal-
organiz-
ns. Re-
entatives

d of the
al funds.
of State.
nds, the
agencies.
e elected.
d Social
nds. It
pervisory
are also
ributions
the Min-
efer to it.
y special
regional

functions
5, on the
oluntary

th insur-
who are
rdless of
rance re-
mpulsory

primary fund, deducting the employees' share from their wages. The primary fund then transmits to regional and national funds the part of the contributions due them, on an apportionment basis determined annually by the Minister of Labor and Social Security. Employers with less than 10 employees and the self-employed pay contributions on a quarterly basis; all other employers and the voluntarily insured pay on a monthly basis.

Doctors who work under social insurance are paid on a fee-for-service basis. Insurance patients have free choice of physician. Fee schedules set by agreements between insurance funds and local medical societies, become effective after approval by a special national commission composed of representatives of the funds, medical practitioners, and the ministries concerned. If agreement on fee schedules cannot be reached locally, this commission fixes the rates. Usually, the insurance doctor is paid directly by the patient, and the latter is then reimbursed by the funds in terms of the established fee schedules. The fee for a specific service performed by an insurance doctor is determined by the product of a key-letter (which denotes the type of treatment, e. g., "K," for specialist and surgical care, and the value of which is established for each province) and a coefficient (representing the relative value of the treatment itself) set nationally and published in an official list of professional services performed by all classes of medical practitioners. Special regulations in March and April 1946 increased from 80 percent to 100 percent the reimbursement to insured patients for any treatment, whether by a general practitioner or specialist, on the established list of professional services with a coefficient of 50 or more. Also, since May 1946, doctors are prohibited by law, except in specified circumstances, from charging insured patients more than the scheduled fee for a specific service. All expenses for medical treatment in connection with maternity or long-term illness are reimbursed 100 percent. The value of "K" in Paris and other large cities is now Fr. 75.

Hospital fees for bed, board, and other services for insured persons and their dependents are arranged, in general, by contract between funds and particular hospitals. The patient pays the hospital directly and is reimbursed up to 100 percent under the new regulations. The charges for general practitioner services in a hospital are added to the patient's bill, and he is similarly reimbursed by the funds.

The expenditure in 1945 for cash sickness and medical benefits is shown by the following table (*18*):

Type of expenditure	Amount, in francs	Percent of total
Total	6,291,000,000	100.0
General practitioner services	867,000,000	13.8
Surgical care	348,000,000	5.5
Drugs	888,000,000	14.1
Dental care	237,000,000	3.8
Hospital and free care	773,000,000	12.3
Daily cash benefits	3,005,000,000	47.8
Medical control	173,000,000	2.7

Cash benefits.—Sickness: The daily cash benefit for short-term illness, under compulsory insurance, is equal to one-half the basic daily earnings of the insured person, up to a maximum of Fr. 150 a day. If he has three or more dependent children, the rate is increased to two-thirds the daily earnings from the thirty-first day after the illness begins. If institutional treatment is required, the daily benefit is reduced by fifths, according to the number of dependents of the insured (by three-fifths if he has no dependents). For long-term illness, a monthly cash allowance 30 times the daily grant for short-term illness is paid by the funds, up to a maximum of Fr. 4,500 a month, or Fr. 6,000 if the insured has three children. If hospital treatment is required, the same reductions are made as in the case of short-term illness. The daily benefit for short-term sickness is limited to 6 months for the same illness; for long-term illness, the duration of the benefit may extend to 3 years. To receive cash benefits for long-term sickness, the insured person must undergo a special examination before the end of the third month of illness. This examination is made by the attending doctor and the medical adviser of the fund. To get cash sickness benefits, the insured person must notify the primary fund of his condition within 3 days after the onset of the illness.

Invalidity: Any insured individual whose earning capacity has been reduced by two-thirds may receive an invalidity pension, payable quarterly. If he is able to do part-time work, his annual pension amounts to 30 percent of his average

r work,
t assist-
-percent
r, exceed
the age
n cannot

y, calcu-
ks before
omplica-
monthly
ling phy-
he value
ount and
lowances
ablished
en regis-
finement
l.
eral and
ng neces-
medical
s, clinics,
ry) ; and
medical
10 years
medical

ing preg-
that she
the fund

control centers, which, in turn, supervise the local health-insurance organizations. These insurance organizations are the approved societies which formerly administered the voluntary system. Persons covered by the system must enroll either in an approved benefit society of their choice or in the regional office of the National Sickness and Invalidity Insurance Fund of the area in which they live. The benefit societies and regional offices determine eligibility, pay cash benefits for sickness, maternity, and invalidity, and reimburse insured persons for medical expenses, including expenses for care of their eligible dependents.

Coverage.—Coverage is compulsory for nearly all persons bound by an employment contract. About half the 8,300,000 persons in the Belgian population receive their medical care through the health-insurance system. In 1946 the system had about 1,700,000 insured persons—20,000 enrolled as members of regional offices, and 1,650,000 as members of the 2,500 approved benefit societies, which are federated in five groups (Socialist, Catholic, Professional, Neutral, and Liberal). With eligible dependents of insured persons—young children and dependent parents, aged 55 or over—the number of persons eligible for medical benefits totaled about 4,000,000. Among the excluded groups are the self-employed; persons engaged in agriculture, domestic service, fishing, services in inland navigation, family employment, public employment; merchant seamen; and employees of the National Belgian Railway Company. All excluded groups may later be included by royal order, and coverage for self-employed persons is planned for 1947.

Financing.—For each quarter, employers send to the National Social Security Office the total amount of employer and employee contributions payable for the period toward the whole social-security program. That Office then sends to the National Sickness and Invalidity Insurance Fund the amounts allotted to health insurance, and the Fund, in turn, distributes to benefit societies and regional offices the sums which represent contributions by or on behalf of their members. These sums are determined on the basis of contribution certificates which employers give their employees to indicate the amount of wages from which the employees' health-insurance contributions have been deducted. The worker must give or send this certificate to the benefit society or regional office in which he is enrolled to show that his contribution record is in order. The certificates are sent each quarter to the National Sickness and Invalidity Insurance Fund.

Some 140,000 employers contribute for the health and invalidity insurance program 2.5 percent of the wages of manual workers and 2.25 percent of the salaries of office workers. Insured persons contribute 3.5 percent of their wages if they are manual workers and 2.75 percent of their salaries if they are office workers. For both employer and employee contributions, only the first Fr. 4,000 a month of remuneration is taxable.

The National Government adds a sum equal to 16 percent of total health insurance contributions as a subsidy to improve medical care. In 1945, the Government contribution was Fr. 350,000,000, or about Fr. 87.5 ($1.75) per person eligible for medical benefits. The National Sickness and Invalidity Insurance Fund also contributes toward medical care for certain noncontributing persons and their families (old-age, survivor, and invalidity beneficiaries; families of persons called to the armed forces; and persons involuntarily unemployed).

Under the former voluntary system, members' contributions varied among funds; employers sometimes contributed for their employees who were members of mutual benefit societies organized for specific occupational groups; and the National Government paid approved societies a subsidy which approximately equalled the members' contributions.

Under the new program, doctors, dentists, midwives, and pharmacists signify each year, at the invitation of the National Fund, their willingness to participate in providing medical benefits under the fee schedules established by agreement between the professional organizations and the National Fund. Each union of mutual benefit societies and each regional office has medical advisers on its staff determined in proportion to its membership (1 medical adviser per 25,000 persons eligible for medical benefits). These medical advisers give no medical treatment; they are responsible for seeing that the medical treatment is effective and economical and for authorizing hospitalization and other special medical benefits.

Insured persons pay their own bills for general medical care, and the insurance organization reimburses them for three-fourths of their payments for office calls and two-thirds of their payments for home calls. The insured person pays no fees for hospitalization, care of specialists, or other special benefits, but, on recommendation of its medical adviser, the insurance organization may curtail these benefits in some cases. A lump sum is paid to an insured woman to cover medical

trol, she
person is
cluded in

s legally
wise can
nister of
group of
nths or a
uch care
a small
d repre-
nsurance
at for a
tions in
and un-
esenting
be multi-
actor of

eligible
rage re-
payable
kers and
atter 30

nds, but
r. 2 for

ss bene-
es work

invalidity pensions will require higher contributions and provide larger basic benefits, with supplements, related to need, to take account of geographic variations in the cost of housing and fuel. Contributions will be collected, as they now are, with income and property taxes, but pensions will no longer be related to contribution records.

Changes in the existing voluntary health insurance system are even more far reaching. On December 18, 1946, the Riksdag approved a bill to establish a compulsory system, to be effective in 1950, which will insure all persons for certain medical benefits, without age, health, income, or occupational restrictions.[6] Under other proposed legislation, free hospital care will be available to the entire population.

Sweden's first national legislation to control and subsidize the operations of sickness funds was enacted in 1891. Subsequently, a basic Sickness Funds Order of 1931 (effective in part in 1935 and in part in 1938) required that, in addition to paying cash sickness benefits, approved funds should reimburse their members for medical expenses; called for registration of all funds with 50 or more members; and provided larger national subsidies. The voluntary system that has evolved through the years has been relatively limited in coverage and in scope of medical benefits. It should be considered, however, in relation to the extent to which rich and poor alike use tax-supported hospitals and other public-health facilities. Through district and municipal physicians, nurses, dentists, and hospitals, medical care of sick persons—at a small charge if they are able to pay—is closely associated with general public health services.

Administration.—The new compulsory health-insurance program will use the administrative machinery of the existing voluntary system. At present, the Royal Pension Board in the Ministry of Social Affairs carries national responsibility for approval of sickness funds, supervision of their activities, and authorization of national subsidies; it also administers the compulsory old-age and invalidity pension program. The Royal Medical Board in the same Ministry is the central authority responsible for determining national standards and issuing regulations for medical benefits. Local governments, district and municipal, administer public medical services through salaried physicians, dentists, nurses, midwives, and hospital staffs. Many of the salaried doctors receive fees under the health-insurance system for serving members of sickness funds.

Nearly all functions of health insurance administration are carried by local sickness funds (1,700 in 1946, 1,645 in 1943). Most of these funds are general or community funds, though some cover employees of individual factories or other occupational groups. As a rule, each rural area or small town has only one local fund, while large communities are divided into several districts, each with its own local fund. All local funds are attached to a central fund (29 in 1946, 28 in 1943), and all members of local funds must thus be indirect members of that central fund. Central funds pay cash sickness benefits to their indirect members after the exhaustion of rights to benefits in the local fund.

Coverage.—The new compulsory system will waive all coverage restrictions for medical care, but only gainfully employed persons will be insured for cash sickness benefits. Under the existing voluntary system, persons must be in good health and aged 15–40 (in some funds, aged 15–50) when admitted to membership in a sickness fund, and an income restriction applied to coverage for medical benefits excludes persons whose annual assessment for national income and property tax exceeds 8,000 kronor (about $2,240).

On December 31, 1943, a total of 2,147,381 men and women, or approximately 42 percent of the adult population of Sweden, held membership in approved sickness funds. All women members were covered for maternity benefits, and 2,025,000 members had insured their children under age 15 for medical benefits. The total adult membership at the end of 1943 was distributed as follows (*53*, p. 8):

Insurance carried	Total	Men	Women
Total	2,147,381	1,046,867	1,100,514
Medical benefits only	65,739	11,951	53,788
Cash sickness benefits only	115,439	83,420	32,019
Both types of benefit	1,966,203	951,496	1,014,707

---

[6] No information is yet available on the date of royal assent or statute number of the new health insurance law; data on the program are taken mainly from the Government's bill, introduced September 27, 1946 (*48*).

under

tribute
ts pro-
endents
varied
benefit
dren of
person
nd his

health
ational

subsidy
medical
res for
be one-
ickness
ear the
of in-
ich are
. 75 per
ternity
e exist-
of hos-
ational

as Kr.

Cash benefits.—Sickness: Under the new law, nearly all gainful workers will be insured for a uniform amount of Kr. 3.50 a day, with supplements for the wives and children of insured men.[7] The waiting period will be 3 days and the benefit will be payable for as much as 730 days. At present, persons who insure for cash benefits receive, after a 3-day waiting period (which is sometimes increased to 7 days), a daily amount ranging from Kr. 1 to Kr. 6. The benefit is now payable for 18 days by some local funds and for 90 days by those whose reserves are adequate; thereafter, the central fund with which the local fund is affiliated pays the benefit up to a combined total of 2 or 3 years for any one illness. To be eligible, a member must show that a physician has ordered him to abstain from work, or that illness has reduced his working capacity by at least one-fourth.

Maternity: No information is yet available on the legislative status of proposals to increase the cash maternity benefit and provide it, on a noncontributory basis, for all confinements. The lump sum proposed would be Kr. 200 (now Kr. 110); in addition, employed women would have a daily benefit of Kr. 2–7, depending on their income, payable for 180 days; other women would receive Kr. 1.50 a day for 90 days. Under existing provisions, sickness funds pay the lump-sum maternity benefit only to an employed woman who has been a member for at least 270 days before confinement.

Invalidity: Under the new law for old-age and invalidity pensions, the basic invalidity pension will be Kr. 1,000 a year for a single person, with supplemental amounts based on need. At present the basic amount is Kr. 70, increased in proportion to contributions paid and the pensioner's need. It is payable to any person aged 16–66 whose working capacity is reduced by two-thirds or more.

Medical benefits.—The proposed health security system includes hospital services for the entire population without charge, free drugs and medicines obtained on prescriptions, and other medicines at half cost. Medical benefits under the compulsory health insurance program will include reimbursement for three-fourths of amounts set in fee schedules for general practitioners' services and X-ray examinations and treatment by specialists. With other provisions for a comprehensive program of dental care, authorized in 1939, and recently expanded provisions for maternal and child health, both outside the health insurance system, the proposed health services financed from public funds will encompass broad fields of health security for the entire population.

Medical benefits under the present system now vary among funds. They are available without duration limit (except for hospitalization) to insured persons who meet the eligibility requirements and to the young children of members who have contributed on their behalf. General practitioner services comprise consultations and visits at the physician's office or in the patient's home. Specialist care is provided as part of the hospital benefit, which includes ward care for as long as 2 years (3 years in some funds) for any one illness. A few funds include X-ray and physiotherapy services, and a few pay part of the costs of drugs and medicines.

Denmark

The war and the nearly world-wide concern with measures to extend the scope of social insurance and health services have not greatly affected existing social security programs in Denmark or plans for the future. The reason lies, perhaps, in the breadth and integration of the programs established under the Social Reform Acts of 1933, as well as in the extent to which hospital and other medical services are available at minimal or no charge to nearly all the Danish population. Through liberal grants from national and local tax revenues and the mechanisms of social insurance and public assistance, virtually the entire population has long been protected against the fear of want in old age, invalidity, unemployment, and illness.

In its Sickness Fund Act of 1892, Denmark closely paralleled Sweden by establishing national standards and subsidies for voluntary sickness funds. Since 1921 the distinction between voluntary and compulsory membership in these funds has been virtually obliterated in Denmark. Nearly all persons of working age must pay contributions to the invalidity insurance system, and since these contributions are collected by the sickness funds of the health insurance system, membership in these funds is obligatory. Membership, however, may be passive (without rights to medical or cash benefits) or active (with such rights). Fines, larger in amount than the annual dues for passive membership, and loss of rights

---

[7] Amounts will be lower for adolescents and aged persons. All amounts may be increased through voluntary insurance.

s strong
system.
f Social
ermines
d other
Directo-
er mem-
ne maxi-
on of the
Council
unds.
Sickness
termines
validity
l to con-
provide
ncial aid

rea, are
unds are
ts of the
pproval,
at mini-
ere 1,591
nds elect
ation of
ectorate.
member-
medical
ve mem-

death benefit is the minimum of Kr. 100 or the maximum of Kr. 300. In addition, active members pay the same contributions toward invalidity pensions as do those with passive status.

Sickness funds collect the monthly contributions from their active members and affix stamps in the members' books to indicate that the contributions have been paid; the funds also collect the annual dues for passive membership and the annual premiums for invalidity insurance. The penalty for failure to pay contributions is Kr. 13 a year, and in certain circumstances may deprive persons of rights to regain active membership, or qualify for invalidity or old-age pensions. Employers do not contribute toward their employees' medical and cash sickness benefits but pay Kr. 6 a year toward invalidity pensions for those whom they employ for a full year.

The National Government pays each approved sickness fund a subsidy of Kr. 2 a year for each active member, plus one-fourth of the amount the fund expends for medical and cash benefits. In addition, the Government pays three-eighths of the fund's expenditures for medical and cash benefits to persons who have a chronic disability on admission. No subsidies or Government payments go to the 18 sickness benefit societies which insure persons in higher income groups.

The local government pays membership contributions for persons who are unable to pay their own dues and subsidies for those who are already disabled when they enter a sickness fund. They either defray the entire costs of hospital care or charge the sickness fund only half the rates nonmembers pay for ward care. In addition, national and local governments share in meeting the costs of invalidity pensions in excess of the amounts contributed.

In 1944, the income of subsidized sickness funds amounted to Kr. 127,321,268, derived as follows (*62*, p. 19):

Source	Amount, in kroner	Percent of total	Source	Amount, in kroner	Percent of total
Total	127,321,268	100.0	National subsidies	28,765,655	22.6
			Commune subsidies	3,680,128	2.9
Contributions:			Interest	1,454,395	1.1
Active members	82,824,320	65.1	"Control tickets" [1]	1,382,881	1.1
Passive members	674,677	.5	Other	8,539,212	6.7

[1] Special charges for calls at night or on Sundays or holidays.

Expenditures of subsidized sickness funds amounted to Kr. 123,932,602 in the same period, or Kr. 52.11 per active member (*62*, pp. 20–21):

Type of expenditure	Amount, in kroner	Percent of total	Type of expenditure	Amount, in kroner	Percent of total
Total	123,932,602	100.0	Appliances, spectacles, etc.	1,643,710	1.3
			Home nursing	1,737,665	1.4
General practitioner services	28,326,608	22.8	Cash sickness benefits	9,721,570	7.9
Specialist services	5,562,790	4.5	Cash maternity benefits	6,693,245	5.4
Hospitalization	20,308,612	16.4	Funeral benefits	5,496,890	4.4
Dentistry	6,233,301	5.0	Administration	13,280,013	10.7
Medicines	14,316,154	11.6	Other	10,612,044	8.6

During the same period, expenditures of the invalidity insurance system amounted to Kr. 52,148,961.

At the beginning of each fiscal year, active members of the sickness funds indicate the physician of their choice. About one-third of the subsidized funds, which together have about two-thirds of the total membership, use the capitation method of remunerating physicians. The other funds, mainly those in rural areas, use a fee-for-service method. Under both methods, the physician may charge a small added fee for certifying illness and for night, Sunday, and holiday calls. The capitation amounts and fees for service are agreed on by sickness funds and practitioners, but to be valid must be approved by the Minister of Social Affairs. The sickness fund pays the physician quarterly. The capitation fee varies among funds and differs with the scope of services provided. For a general practitioner in Odense, for example, it is Kr. 9 a year for each insured person (with or without children) on his list, but is 50 percent higher for insured persons who have a chronic disease when admitted to membership.

d mem-
s well as
insure
payable
otracted
member
validity

sickness
equal in
usually
nuch as
ave. It
hat con-
n.
earning
on sex,
sed by a
ditional
nd by a
hes age
tely the

nd must
services
e mem-
nd liver
of spe-
part of
nember-

security system. Prepared in 1943 by the Government-in-Exile, these plans propose greater financial participation by the National Government in the provision of social security benefits.

Administration.—Compulsory health insurance in the Netherlands is administered under two statutes: the Sickness Law of 1929, providing cash benefits for wage losses during illness; and the Sickness Funds Decree of 1941, providing medical benefits. The cash-benefit system is administered by the Social Insurance Section of the Ministry of Social Affairs and the medical-benefits system by a director responsible to the Minister.

Locally, the Sickness Law of 1929 is administered largely by 24 regional labor boards and by approved industrial associations. The labor boards, public bodies made up of employer and employee representatives, are charged with administration of many of the social insurance programs, including invalidity and old-age pensions and children's allowances. The activities of the labor boards are supervised by the National Insurance Bank. This bank, governed by an 11-man council appointed by the Minister of Social Affairs, holds the funds contributed toward social insurance programs and is authorized to make regulations concerning them.

Approved industrial associations—nonprofit organizations established jointly by central bodies of employers and workers—also administer cash sickness benefits under the compulsory program. Employers may insure their employees for cash benefits either with the Government-controlled labor boards or with private industrial associations. If an employer does not insure for cash benefits with the associations, his employees are automatically covered in this respect by the labor boards. A large majority of employers in the Netherlands are insured with the industrial associations. By-laws of the associations must be approved by the Minister of Social Affairs.

The insurance work of the labor boards is coordinated by an Association of Labor Boards, and most of the industrial associations belong to a Federation of Industrial Associations, which is authorized to administer the cash-benefit system for its component associations. The Federation, in turn, is affiliated with a private agency called Centraal Beheer (Central Management); in addition, this agency serves mutual benefit societies and commercial insurance companies offering various kinds of voluntary insurance benefits. Centraal Beheer does not insure any risks itself, but merely administers the insurance systems of many of its member organizations. It collects contributions, pays cash benefits, and organizes medical control for some of the industrial associations belonging to it by virtue of their membership in the Federation.

The Sickness Decree of 1941, establishing compulsory medical care insurance, is administered by special funds, called general sickness funds. At the time the decree was promulgated, there were in the Netherlands more than 650 mutual benefit societies of various types, providing voluntary insurance for medical care. Some of them were approved by the Government, under the decree, as "General Sickness Funds" and authorized to administer the compulsory program for medical benefits; on April 1, 1946, there were 170 such funds. Lump-sum funeral grants, provided for by the 1941 Decree, are also administered by the general sickness funds. These funds must submit their by-laws to the Minister of Social Affairs for approval.

Coverage.—In general, all persons subject to the Sickness Law of 1929 are also compulsorily insured for medical care under the Sickness Funds Decree of 1941. Covered by both statutes are employees under age 65 who earn not more than 3,000 gulden (about $1,140) a year.[8] Contributions toward medical benefits cover, in addition to the insured person himself, his dependent spouse, his children under age 16, and, under certain conditions, his dependent parents and his spouse's parents.

Self-employed persons are not required to carry health insurance, but may insure themselves on a voluntary basis for medical care with one of the general sickness funds and for cash benefits with the labor boards, provided their annual income, if they live in cities, does not exceed G. 3,000. The income limit for this type of voluntary insurance varies from G. 2,000 to G. 2,500 for self-employed persons living in rural areas. Compulsory and voluntary insurance accounts maintained by the same sickness fund must be administered separately.

Approximately 3,500,000 persons were included under both types of compulsory health insurance on December 3, 1945, and another 2,550,000 were volun-

---

[8] A bill has recently been introduced in Parliament to raise the income limit for the compulsory insurance system for cash sickness benefits to G. 3,750 a year.

-thirds

health
coastal
iseases
rnment
arn less
rnment

ne does
l under

ne com-
percent
ce cash
yee) to
er, who

nds for
and the
associa-

neet the
collect
ith the
ution to
embers.
benefits
rnment.
ade on

General practitioners are paid by the capitation system, receiving an average remuneration in cities of G. 3.50 per year per individual on their panel from the general sickness funds; a general practitioner with his own dispensary is paid G. 5.20 as a capitation fee. The funds pay specialists, in general, on a fee-for-service basis. These fees vary greatly throughout the country, in accordance with fee schedules which are drawn up by individual funds and doctors, and are comparatively uniform only in large cities.

The funds pay the municipal authorities, in large cities, a certain amount per insured person per year for hospital care; the individual hospitals are then paid by the municipality for care of insured patients. In rural areas, direct payment is usually made to hospitals by the funds.

Many of the general sickness funds operate dental clinics, paying dentists at the rate of G. 5.75 per hour.

Cash benefits.—Sickness: Cash benefits for illness are payable to an insured person for a maximum of 26 weeks, starting on the third day after the onset of the illness. The allowance, paid for each day during this period except Sunday, usually amounts to 80 percent of the average daily wage earned during the preceding 13 weeks, although, in certain cases, the Government may approve payment of a benefit equal to 90 percent of the average wage. The maximum daily wage on the basis of which the cash benefit may be calculated is G. 8. In certain circumstances, the 3-day waiting period may be reduced and the duration of benefits extended to 12 months. If an insured person receives cash payments for the same illness for a total of 156 days in a 12-month period, he may not receive cash benefits for more than 78 days for that ailment during the following year. Certification of incapacity for cash-benefit purposes is not done by attending doctors, but by special control doctors.

Maternity: A lump-sum grant of G. 55 is given for maternity whether the woman is insured in her own right or is the dependent of an insured man. This grant is made, however, only if a midwife attends the delivery. The midwife's fee and that of the obstetrical houskeeper-aide are usually met out of this sum. For 6 weeks before and after confinement, an employed woman receives, in addition, cash benefits equal to her full salary, up to a maximum of G. 8 per day. The postnatal payment may be extended to 6 months if childbirth causes incapacity for that length of time.

Invalidity: When the income of an employed person compulsorily insured for invalidity benefits drops to one-third of normal because of disability, he receives a weekly cash benefit, provided his employer has made 150 weekly contributions on his behalf. The amount of the pension is directly related to the number and amount of contributions made by the employer. Temporary invalidity benefits may be received after 6 months of illness, and permanent benefits whenever the fact of permanent invalidity is established thereafter. Those compulsorily insured for invalidity must register individually with the labor boards. Before the war, the maximum pension was G. 6 a week, but it has now been increased by a grant from the National Treasury to include allowances for dependent children of the insured person.

Medical benefits.—Medical benefits for compulsorily insured individuals and their dependents include general practitioner care; surgical, obstetrical, and other specialist treatment; hospitalization for 42 days; all necessary medical and surgical appliances; some dental treatment; ambulance service; and part of the cost of care in a tuberculosis sanitarium. Dental work for which the sickness funds pay in full includes extractions, surgery, and cleaning. Dentures are paid for in part by the funds; crowns and bridges must be paid for by the insured person himself.

In maternity cases, an insured woman or the dependent of an insured man is covered for all necessary obstetrical care. Usually, this is accomplished by the G. 55 cash grant provided for payment of the midwife and obstetrical housekeeper-aide. Specialist care during confinement is furnished by some sickness funds, but usually only if the midwife considers it necessary.

Although all drugs are free to those insured for medical benefits, doctors are often limited in the total cost of drugs they may prescribe. Some funds specify that a physician must pay for any drugs he prescribes above a limit set in terms of the average cost of drugs prescribed by the other doctors of the fund.

References

The references cited below were consulted to supplement data obtained through interviews with Government officials, medical practitioners, and others concerned with the administration and operation of hospitals, public health services, and social-security programs in the countries visited.

81. His

Majesty's

The Mac-

94. His

and Cox,

the Pro-
y Office,

Years of

rch, 1945.

al Health
(1944).
Medical

mittee on
London

Contrib-
Majesty's

Govern-
730. His

France—Continued

(*27*) Ministère de la Santé Publique et de la Population: Application de l'ordonnance du 2 Novembre 1945. No. 36. Paris (February 9, 1946).

(*28*) Ministère de la Santé Publique, Direction de l'Hygiène Sociale: Application de l'ordonnance du 2 Novembre 1945. Circulaire No. 148 (June 6, 1946).

(*29*) Ministère du Travail et de la Sécurité Sociale, Direction Générale de la Sécurité Sociale, 8ème Bureau: Circulaire No. I. S. S., 1946. Paris (January 3, 1946).

(*30*) ———: L'Organisation de la sécurité sociale. Revue Française du Travail, 1: 43–46 (April 1946).

(*31*) ———: Loi No. 46–1146 du 22 Mai 1946, portant généralisation de la sécurité sociale.

(*32*) ———: Décret du 8 Juin 1946. Paris.

(*33*) ———: La généralisation de la sécurité sociale. Revue Française du Travail, 1: 230–232 (June 1946).

(*34*) ———: Les tarifs médicaux en matière d'assurances sociales. Revue Fraçaise du Travail, 1: 477–481 (August–September 1946).

(*35*) Secrétariat d'Ftat à la Présidence du Conseil et à l'Information, Direction de la Documentation: Généralisation de la Sécurité Sociale et de la Retraite des Vieux. Conférence de Presse de M. Ambroise Croizat, Ministre du Travail et de la Sécurité Sociale. Hors série No. 99 (May 2, 1946).

(*36*) United States Department of Labor: Sickness and maternity insurance in France. oMnthly Labor Review, 46: 622–637 (March 1948).

Belgium

(*37*) Fuss, Henri: Social security in Belgium. Annals of the American Academy of Political and Social Science, 247: 117–124 (September 1946).

(*38*) International Labour Office: Legislative Series 1944. Belgium 2, Legislative Order: Social Security. Mercantile Printing, Ltd., Montreal (1945).

(*39*) ———: Legislative Series 1945. Belgium 3, Legislative Orders: Miners; Belgium 4, Orders: Sickness and Invalidity Insurance; Belgium 10, Order: Social Security (Seamen). Mercantile Printing, Ltd., Montreal (1946).

(*40*) Ministère du Travail et de la Prévoyance Sociale: Bulletin d'Information du Fonds National d'Assurance Maladie-Invalidité. Special No. March 25 and May 20, 1946. Brussels (1946).

(*41*) L'Institut National de Statistique: Bulletin de Statistique, 32: 649 (August 1946).

(*42*) Sand, René: Les effets de la guerre sur la santé de la population belge. Archives Belges de Médecine Sociale et d'Hygiène et Revue de Pathologie et de Physiologie du Travail, 4: 7–25 (March 1946).

(*43*) ———: Health problems. Annals of American Academy of Political and Social Science, 247: 92–97 (September 1946).

(*44*) ———: Un Programme du la Santé pour la Belgique. Actualités Sociales No. 12. J. LeBègue & Cie., Brussels (1945).

(*45*) Special Committee (Canada) on Social Security: Health Insurance; Report of the Advisory Committee on Health Insurance Appointed by Order in Council P. C. 836 Dated February 5, 1942.

Sweden

(*46*) Act: Lag om folkpensionering (1946, nr. 431–433). Svensk Författningssamling.

(*47*) American-Swedish News Exchange, Inc. News from Sweden, Release No. 265. New York (January 2, 1946).

(*48*) Bill: Kungl. Maj:ts proposition nr. 312 till riksdagen med förslag till lag om allmän sjukförsäkring, m. m. given Stockholms slott den 27 September 1946.

(*49*) Broberg, Rolf: Huvuddragen av den nya folkpensioneringen. Folkpensioneringen, No. 6: 136–146 (1946).

(*50*) Hohman, Helen Fisher: Old Age in Sweden; A Program of Social Security. Federal Security Agency, Social Security Board. Washington (1940).

(*51*) International Labour Office: Sweden 6. Legislative Series 1931. Orders and Notification: Sick Funds, Maternity Benefit. E. Birkhaeuser & Co., Basle.

Norstedt

ialutred-

Tryckeri-

Argangen

–47).

ingsfore-

niversity

mellem
og Fyns

ness, In-
2).
tance in

Sygekas-

1937. E.

e Paint-

Senator MURRAY. That's bad publicity to use in discussions of the problem.

Dr. DAVIS. The medical propaganda machine has tried to throw a lot of scare into people about costs, particularly by talking as if national health insurance payments would be a new tax out of people's pockets. Actually, the majority of Americans are now spending an average of 3 percent of their income annually for the physicians and hospital services which would be available under the bill S. 1320. The health-insurance payments of these people would be a substitute for, not an addition to, these present expenditures.

Let me call attention to two charts which have been clipped from the May 1947 issue of Fortune magazine. I have a few copies of them and if you care to have them I will give them to you. The charts I refer to are these two—the blue and the green. The accompanying text clearly explains their significance, and the charts follow a long article in Fortune representing a general economic study of conditions, of which the medical part is merely a small fraction. These are rather beautiful charts, and they present a graphic picture.

Senator MURRAY. Are you offering those charts for the record?

Dr. DAVIS. If it is feasible to reproduce those two charts and not the whole document, it would be advantageous to have them incorporated in the record so that they would be available to anyone reading it, although I have tried to word my testimony so that it is self-explanatory without the visual aid of the charts.

Senator SMITH. You mean the charts under the heading, "What they spend to stay alive"?

Dr. DAVIS. Yes, sir; those two charts.

The blue chart, which is the second one, shows the total percentage of family income. That is the chart with the blue bars on it. It shows the percentage of family income spent for medical care by American families of different levels. The lower the income, the higher the percentage. The higher the income, the less the percentage spent for medical care. This seems unfair, but unhappily it is true. In actual figures the families with incomes under $1,000 a year—and they constituted about 20 percent of the people in 1945—spent from 5 percent to 8 percent of their income for medical care. The big middle-income group, which constituted about 70 percent of the population in the same year, spend about 4 percent of their income for medical care. Medical care here means all forms of medical care, including dentistry, as well as drugs, hospitals, and physician's care. The top 10 percent of the people spend only 2 to 3 percent for care.

Now the charges levied under the national health insurance bill would be a percentage of earnings, 3 percent, in fact, calculated up to earnings of $3,600 a year. This 3 percent would be paid in full by self-employed persons, or 1½ percent by employed persons for whom the employer pays the other half. Even the low-income people who paid 3 percent would be better off than they are now, and the middle group would be paying about the same, even if they paid the whole 3 percent.

Senator MURRAY. Do you want to offer these charts for the record at this time?

Dr. DAVIS. Yes; I think it would be a good idea to have them in the record.

(The charts referred to follow:)

0 +

Dr. DAVIS. Contrast this situation with the voluntary insurance plans which always charge a flat rate, not varied with income. The charges of the medical society plans and their affiliated hospitalization plans—that means many of them are affiliated with the Blue Cross plan—run from $50 to $60 per year per family, and these plans usually cover only care in hospitalized illness, which average only about half the total costs of medical care to a family.

A $1,000-a-year family which joined one of these plans would have to double its average yearly expenses for medical care. A $2,000-a-year family would have to add 50 percent to its medical expenditures if it joined. Half of the our population earns less than $2,000 a year, even in this time of full employment.

Instead of these voluntary plans being cheap, they are expensive. I would like to add there that I mean expensive in relation to the paying power of a considerable part of our population. They are so expensive in proportion to the incomes and spending habits of many people that their sponsors now want Government subsidy for them. The Taft-Smith-Ball-Donnell bill makes a pass at offering a subsidy. By "making a pass" is explained in the language that follows. But look at these charts and think about these figures. You will then come to the conclusion that the subsidies would have to mount up to something like $2,000,000,000 a year before most of the American people would be served; that is, this would be the case if Americans would accept the charity label which this bill would plaster on their faces, and if the difficult administrative problems of running such subsidies could be worked out.

In fact, S. 545 is essentially a bill starting a system of State medicine, the cost of which would fall mostly on the income-tax payers of this country, and therefore especially on the high-income-tax payers. The national health insurance bill, S. 1320, by contrast, would enable the mass of the people to pay according to their ability into the national health fund, and the supplementary amounts required from general taxation would be relatively small.

All voluntary plans are not expensive. There are plans controlled by the people who pay the bills, in cooperation with an organized staff of doctors, which offer comprehensive medical and hospital services at much lower cost. Some of these plans provide complete medical services at a cost of $20 to $25 per capita, or $60 to $80 per family per year. That is complete medical service. The reason is that they have an efficient form of professional organization—that is, group practice—and a form of administrative organization which gives incentive to disease prevention and to financial economy.

These plans are precisely the type which organized medicine has most strongly opposed. This type of plan might be wiped out by the medically controlled administrations which S. 545 would set up and by this bill's failure to include any antimonopoly provisions. Certainly further development of this type of plan would be stopped by S. 545. Under S. 1320, on the other hand, existing plans of this type would be protected and new ones could be started by either laymen or physicians, or by a body including both.

That concludes my testimony. The remainder of my statement is merely a summary of the points. I don't think you want me to read those into the record. They are already in the record as part of my complete statement, and there is no point in taking up your time.

me ques-

ct?

Columbia

r vicinity

mmission
1920 and

rector of

8 to 1936,

n dispenalthough I have been perhaps brutally critical of some of the aspects of the behavior of organized groups of doctors.

Senator DONNELL. Quite a few of these doctors in Boston with whom you came in contact were members of the American Medical Association, were they not?

Dr. DAVIS. I think we did not accept any—I don't think any of our staff were not members of the County Medical Society of Boston or of the immediate vicinity, and that is the basis of their membership in the American Medical Association.

Senator DONNELL. Yes.

Now, with respect to your duties, just generally—I do not want you to go into detail—as secretary of the Commission on Dispensary Development in New York City between 1920 and 1927, did those duties call upon you to come in contact with the doctors there?

Dr. DAVIS. Yes, sir. That committee was a lay committee, with a medical advisory board which was made up entirely of physicians nominated by the New York Academy of Medicine, so I came in contact with the doctors who were active in the New York Academy of Medicine. Dr. Miller was the head of that.

Senator SMITH. I would like to add at that point that this Dr. Miller to whom you refer was associated with my father in medicine for a number of years, and I am sure that you have the same high regard for his devotion to public service, integrity, and skill as I have.

Dr. DAVIS. If I knew of anyone suffering from tuberculosis, an obscure case, there would be nobody in the country in whose hands I would rather see him than in the hands of Dr. Miller, either from the standpoint of his skill or from the standpoint of his complete integrity in devoting his interest to the service of humanity.

Senator SMITH. Did you know that in treating his patients, Dr. Miller never discussed what the fee was? He was willing to serve the poor as well as the wealthy at all times.

Dr. DAVIS. I would have to add to that that despite my great respect and affection for Dr. Miller personally, we have had very violent disagreement on some of the questions we are discussing today.

Senator SMITH. I think that is true, because he does not believe in a compulsory plan, and I can see why the two of you might disagree. But we are talking now with respect to character and from the point of view of conviction to public service. You probably would concede that he would have as high a desire to solve this problem as you have, would you not?

Dr. DAVIS. Without question, sir.

Senator DONNELL. You spoke of the New York Academy of Medicine generally. Did you observe that that same high quality of devotion to professional ideals and the desire to be of public service characterized the members of the New York Academy of Medicine with whom you came in contact?

Dr. DAVIS. Oh, yes. The work of that committee was supported by the Rockefeller Foundation, and it was designed to do certain things, to study clinical standards and to establish improved standards for the treatment of out-patients in charitable clinics and experiment in improving standards of clinics, subsidized by funds from the Rockefeller Foundation. I don't think it is necessary for me to go into further detail.

e more
already
acilities
Then in
ary de-
8 or 9
en com-

als and
f work.
veys of
d what
n I was
ospital
ke them

utions.
as anti-
rebuild
practice

y work
clinics,

ness and their desire to submit themselves to his authority, and they employ him for that purpose.

Senator SMITH. You suggest that a doctor is better at the retail level than at the wholesale level?

Dr. DAVIS. Very much so. I don't mean that in the derogatory sense of those two words, but I think I understand what you mean. Yes, sir.

Senator DONNELL. Dr. Davis, you found then that individually these men, these doctors, all over the United States with whom you came in contact did show the characteristics of zeal and integrity and good intentions; is that right?

Dr. DAVIS. Yes, sir.

Senator DONNELL. I think I understand your view in respect to the American Medical Association. You comment in general detail on that, and I will not go into it at the moment.

Now, you started in with the Rosenwald Fund in 1928; is that correct?

Dr. DAVIS. Yes, sir.

Senator DONNELL. You were with it from then until 1936; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. What was the Rosenwald Fund?

Dr. DAVIS. The fund was—and it is still in existence—a private foundation, a philanthropic foundation, established by Julius Rosenwald, of Chicago, who was living until 1932, at which time he died. He contributed $1,000,000 to it as a capital fund, to be used up within 25 years after his death, principal and interest, and a part of its work was concerned with the study and promotion of improved medical services, and it was that department of his work that I had charge of.

Senator DONNELL. Did you prepare or collaborate in the preparation of a pamphlet entitled "Julius Rosenwald Fund, Eight Years Work in Medical Economics, 1929–36, Recent Trends and Next Moves in Medical Care," issued in Chicago in 1937?

Dr. DAVIS. That was prepared at the time I was preparing to leave the fund. It was drafted by me, and the responsibility for it was in the hands of the president of the fund, but I prepared it in the first instance.

Senator DONNELL. You prepared it, and the statements therein contained are true to your best knowledge and belief; is that right?

Dr. DAVIS. Yes.

Senator DONNELL. I would like to insert in the record at this time this paragraph from page 16 of this pamphlet:

> The members of the staff—

that refers to the staff of the Julius Rosenwald Fund, I take it?

Dr. DAVIS. I presume so.

Senator DONNELL. All right.

> The members of the staff were naturally called on for frequent public addresses. Articles in magazines of general circulation and in the special organs of various professional and lay agencies were prepared, or their preparation arranged for. Some of the more important facts were put into chart form and issued as A Picture Book About the Costs of Medical Care. The illustrations in this report are from the third edition of the Picture Book. Altogether, during the years 1933 to 1936, about 160,000 pamphlets and articles were distributed by the fund, mostly on request.

f the in-
d.
nnection
spend—
he activ-

hat from
now. I

e follow-

TO 1936

I know,

listed in
entioned
four to
5,000, in

lief is it

councils of the American Medical Association. Under his chairmanship, with that status given us, we were able to approach a number of foundations and secure donations from those foundations during the years 1927 to 1932. During those 5 years—a little over 5 years—the committee raised, almost entirely from foundations, something around three-quarters of a million dollars, from the Rockefeller Foundation, the Carnegie Corporation, the Twentieth Century Fund, the Russell Sage Foundation, and two or three other foundations. A total of about $750,000 was raised and expended almost entirely from those foundations during that period from 1928, when the committee got into full and actual operation, to 1932, when it concluded its operations.

Senator DONNELL. And you were a member of that committee?

Dr. DAVIS. I was a member of the organizing committee, as I have described. I became a member of the governing board and of its executive committee. The governing board was a committee of 50 people; the executive committee was a committee of 11 people. I might add that on the membership of that executive committee were a number of physicians, among them Dr. Follansby, who at that time was chairman of the judicial council of the American Medical Association. Dr. West, secretary of the American Medical Association, was a member of the general committee but not the executive committee. The American Medical Association was consulted in the organization of the committee.

Senator DONNELL. On the executive committee was included Mr. Walton Hamilton, now connected with the law firm of which Judge Thurman Arnold is head; that is correct, is is not?

Dr. DAVIS. Yes.

Senator DONNELL. And of which Mr. Abe Fortas is also a member?

Dr. DAVIS. Yes.

Senator DONNELL. Now, Dr. Davis, when you mentioned that figure of three-quarters of a million dollars as having been raised and expended, you were referring to that sum of money having been raised and expended by the Committee on the Costs of Medical Care; is that right?

Dr. DAVIS. That is right.

Senator DONNELL. Over how long a period, did you say?

Dr. DAVIS. From 1927 to 1932—a period of a little over 5 years.

Senator DONNELL. Had you met Dr. Isidore S. Falk prior to the organization of the Committee on the Costs of Medical Care?

Dr. DAVIS. I had met him very casually in Chicago while I was in Chicago at various times. You see, before I went to Chicago with the Rosenwald Fund I had had occasion to visit Chicago many times in connection with consultation work, and when I met him he was then in the department of bacteriology in the University of Chicago.

Senator DONNELL. He left the department of bacteriology about December of 1929, did he not?

Dr. DAVIS. Yes.

Senator DONNELL. And was he made the associate director of study of the administrative staff of the Committee on the Costs of Medical Care?

Dr. DAVIS. He was appointed by the executive committee to the committee selected, and that was a position of great importance. He was the technical director of studies. The general director was Mr.

elations
he tech-
director

the re-

re Miss
, is that

nder the

Rosen-
e money
health

e aid of
chemes.
ity hos-

he Com-
used for
?

Senator DONNELL. Going back to the Julius Rosenwald Fund publications, was there not among other books published by that fund while you were with it, one entitled "The Concept of Social Medicine, as Presented by Physicians and Other Writers in Germany, 1779–1932," that was issued by the Julius Rosenwald Fund, which did pertain to the subject of social medicine, is that right?

Dr. DAVIS. Yes. It was a pamphlet rather than a book. It was purely historical, purely a review, not of the existing systems of health insurance but of the concepts underlying, as manifested in the published literature by physicians and others in Germany during the period covered by the dates you mentioned.

Senator DONNELL. And may I inquire also whether or not among the reprints issued by the Julius Rosenwald Fund while you were with it, was one entitled "Sickness Insurance in the United States" by C. Rufus Uram, published in 1932?

Dr. DAVIS. Yes.

Senator DONNELL. Was there another reprint, of which you yourself were the author, issued in 1934, entitled "How Europeans Pay Sickness Bills"?

Dr. DAVIS. That was an article, I believe.

Senator DONNELL. Was that written by you?

Dr. DAVIS. By me; yes.

Senator DONNELL. And that was issued by the Rosenwald Fund?

Dr. DAVIS. I am a little hazy about that. The article was first published in a magazine. It was later reprinted, and I would have to refresh my recollection as to whether or not the Rosenwald Fund paid for a certain quantity of reprints and their distribution. I am not quite sure about that.

Senator DONNELL. I hold in my hand this same publication to which I have previously referred, "Julius Rosenwald Fund, 8 Years' Work in Medical Economics, 1929–36," and I call your attention to the fact that at page 45 of that publication, under the headline "Reprints," is listed, with a little star in front of it—and the star down at the bottom of the page saying "Out of print"—the words "How Europeans Pay Sickness Bills" by Michael M. Davis, 1934.

That was then issued by the Rosenwald Fund?

Dr. DAVIS. Not the article.

Senator DONNELL. But the reprint?

Dr. DAVIS. As for the reprint, my recollection is that a quantity of the reprints were purchased by the fund for distribution. Perhaps I ought to explain to you how that article was written. I went abroad for some time in 1933 to study health insurance in Europe, and I wrote that article as a byproduct of my trip, and I got the president of the fund, who had the final say about the expenditure of money and just how much could be spent for various things, to make some of these reprints available for distribution.

Senator DONNELL. And the Rosenwald Fund bought some of them and did make them available?

Dr. DAVIS. That is correct.

Senator DONNELL. The office of the Rosenwald Fund was 4901 Ellis Avenue, Chicago; is that correct?

Dr. DAVIS. That is right.

ars this

fields of
Chicago.

not you
of Chi-
vhether

had an
rsity of
is com-
it pos-
s books
would
d. The
ons and
o Press
of con-
he fund

by the
5 of the
he effect
rom the

Dr. DAVIS. As I recall the statement, yes.

Senator DONNELL. Mr. Hamilton served on President Roosevelt's Committee on Economic Security in 1934, which drafted the Social Security Act, did he not?

Dr. DAVIS. I think so, as I recall it.

Senator DONNELL. And he also became the first Director of Research and Statistics of the Social Security Board, did he not?

Dr. DAVIS. I think he served in that capacity for a short time.

Senator DONNELL. In connection with your work with the Rosenwald Fund, did you live in Chicago?

Dr. DAVIS. Yes, when I wasn't traveling.

Senator DONNELL. When you were not traveling?

Dr. DAVIS. Yes.

Senator DONNELL. Subsequently you became the chairman of the Committee on Research in Medical Economics, Inc. You became that about 1937, did you not?

Dr. DAVIS. Yes.

Senator DONNELL. Is that particular organization a committee or a commission?

Dr. DAVIS. A committee.

Senator DONNELL. Did you say "committee"?

Dr. DAVIS. Yes; it is a committee.

Senator DONNELL. It is supported by grants from the Rosenwald Fund, the Rockefeller Foundation, and Mr. Albert Lasker, who testified here this morning; that is correct, is it not?

Dr. DAVIS. The committee has been supported chiefly by foundation grants. Its initial grant was from the Rosenwald Fund. Subsequently we asked for aid from additional other foundations, the Rockefeller Foundation, and later from the Albert and Mary Lasker Foundation, and grants were received from all those foundations.

Senator DONNELL. And you left the committee about January 1928; is that right?

Dr. DAVIS. No. I left the Rosenwald Fund at about that time. Excuse me. I left the committee in 1928. I left the Rosenwald Fund at the end of 1936 and moved to New York to take charge of this new committee, which was practically a committee to carry on specialized work in the field of studies in medical economics, because the Rosenwald Fund—and I concurred in the desire—felt that it would be freer if they had a special committee of people particularly interested in that rather than to be under a general board of a foundation that had a half dozen other major interests.

Senator DONNELL. The Rosenwald Fund in 1936 made the decision that it would be practical for it to turn over certain lines of work to other agencies, did it not, and made a grant of $165,000 to be used over a 5-year period to the Committee on Research in Medical Economics?

Dr. DAVIS. That is right.

Senator DONNELL. When were those lines of work turned over to other agencies; do you recall?

Dr. DAVIS. No; I do not recall.

Senator DONNELL. I would just like to read the paragraph in this article about the Rosenwald Fund, preceding the paragraph in which appears reference to the grant of $165,000:

> The depression greatly accelerated the practical interest in medical economics among the public, among many thousands of physicians, and among public health

nd's work
rtening of
nost satis-
n the past
n this field
of action.

of work

ght you
field. I
ere com-
as termi-
Medical

uary 28,
e Health
lk, were

ppointed

ted con-
ht?
t a con-

Senator DONNELL. May I ask you whether or not on April 2, 1946—last year—there was a committee appointed to lobby for the Wagner-Murray-Dingell bill, namely, the Committee for the Nation's Health; do you remember that?

Dr. DAVIS. The Committee for the Nation's Health, as Mr. Louchheim stated this morning, was organized or became incorporated toward the end of February 1946, and part of its obligation was to do whatever it could to assist in the promotion of legislation. It is definitely an organization which is designed to assist in the enactment of legislation along the lines stated this morning by Mr. Louchheim as being the policy which we are organized to promote and for which we were organized to promote.

Senator DONNELL. And the Committee for the Nation's Health was incorporated in February 1946 under the New York statute?

Dr. DAVIS. Yes.

Senator DONNELL. That is correct; is it not?

Dr. DAVIS. Yes.

Senator DONNELL. Did that committee, namely, the Committee for the Nation's Health, Inc., hold a meeting at the Carlton Hotel in Washington on or about April 1, 1946, with respect to the subject matter of the Wagner-Murray-Dingell bill? Do you remember that?

Dr. DAVIS. I do not recall any meeting of the committee—I do not recall any meeting of the committee at the Carlton Hotel. The meetings of the committees are numerous, and there have been special conferences called by subcommittees. I cannot recall whether there was any meeting of the committee on or about that date at the Carlton Hotel.

Senator DONNELL. May I refresh your memory by asking if you were present at a meeting in the Carlton Hotel at which Messrs. Altmeyer, Lasker, Representative Dingell, Mr. Abe Fortas, Dr. Frothingham, and others were present? Do you remember that?

Dr. DAVIS. There were several meetings. I cannot identify a meeting of that type at a particular date, sir. There were many meetings with some of those people and other people present. There were numerous meetings around about that time.

Senator DONNELL. Without reference to the identification of any particular meeting, do you remember that at one or more of those meetings the gentlemen to whom I refer were present, and Mrs. Keyserling, together with Mr. Raymond Swing and yourself, Dr. Allen Butler, Dr. Ernst P. Boas, and Dr. Goldman were present? Do you remember that quite a few of those meetings occurred at which some or all of those parties were present?

Dr. DAVIS. Yes, sir.

Senator DONNELL. And the purpose of those meetings to which I refer was to advocate the enactment of the Wagner-Murray-Dingell bill; is that correct?

Dr. DAVIS. It was largely in connection with the enactment of that bill or some measure to promote the cause for which the committee was organized, so we held meetings for that purpose.

Senator DONNELL. Going back for a moment to the Committee on Research in Medical Economics, you were chairman of that committee?

Dr. DAVIS. I am chairman.

Senator DONNELL. You are now?

Dr. DAVIS. Yes.

. Peters

vhile we
vhen we
nditions.

ed Med-
the eco-

r. Boas,
Phillips,

?

nt to the
red, that
of 1946;

rsons as
ask you
e execu-
John P.

Dr. Davis. I make that confession.

Senator Donnell. You were there?

Dr. Davis. Yes.

Senator Donnell. Do you recall that seated at the head table, among those seated there, were the following persons: Dr. Ernst P. Boas; Mr. Cruikshank, of the American Federation of Labor, who testified here yesterday; yourself; Representative Dingell; Dr. Channing Frothingham; Mr. Leon Henderson, who testified here the other day, too; Mrs. Frederic March; Senator Murray; and Dr. John P. Peters; do you recall that?

Dr. Davis. I remember the affair. I couldn't list those who were at the table, but I remember the affair very well.

Senator Donnell. Were there funds solicited at that meeting for any purpose?

Dr. Davis. It is a little difficult for me to remember because I go to a good many dinners and there is a tendency now to solicit funds at dinners. At that particular dinner I think funds were solicited, and if they were I think it was probably—you see, the dinner was a very enthusiastic one; the hall, as I recall it, was filled, and the people were all very enthusiastic.

Senator Donnell. Do you recall how much money was raised at that meeting?

Dr. Davis. I don't know.

Senator Donnell. What was the purpose for which funds were solicited?

Dr. Davis. To support the Physicians' Forum.

Senator Donnell. To support the Physicians' Forum?

Dr. Davis. Its membership dues have not been sufficient to maintain its budget.

Senator Donnell. And the Physicians' Forum has as one of its primary objectives the advocacy of compulsory health insurance?

Dr. Davis. I cannot speak for the Physicians' Forum. I am not a member. Only physicians are entitled to be members of the Physicians' Forum, and I am not a physician, as you know. I think the purpose of the Physicians' Forum is more general, much more general, than that of the Committee for the Nation's Health. I would say the purpose of the Physicians' Forum is a broader program of education, particularly of physicians along the lines of advancement in the social and economic problems of medicine; and the advocacy of this particular legislation which they are advocating, as I understand it, is simply one of the things that they do, but it is not their primary function, by any means.

Senator Donnell. Is the advocacy of compulsory health insurance the sole purpose of the Committee for the Nation's Health, Inc.?

Dr. Davis. The Committee for the Nation's Health, Inc., advocates compulsory health insurance, but I would not say that was its sole purpose. I should say its principal aim is the advocacy of a national health program, of which compulsory health insurance is an integral part. For example, this bill S. 1320 includes, of course, compulsory health insurance but also a very substantial program of grants-in-aid to States, which we regard as an extremely important part of, and a necessary supplement to, health insurance. The two things go together.

ever, in
Nation's
Murray-

nization
?

v York

ork?

he same

ve their

ou have

nown as
t of the

er 1944?

Dr. Davis. Yes.

Senator Donnell. And George Soule and Ruth Taylor are also members of that committee, are they not?

Dr. Davis. Yes.

Senator Donnell. The editorial board of the Quarterly Journal issued by that committee is constituted by Dr. Ernst P. Boas, Dr. Bradbury, Dr. Munger, Dr. John P. Peters, Herbert E. Phillips, Kingsley Roberts, George Soule, and Mr. Winslow; is that correct?

Dr. Davis. That is the board as originally constituted, but it has not been in existence since 1945.

Senator Donnell. I should have said that. That is the publication I referred to awhile ago.

Dr. Davis. Yes.

Senator Donnell. And that was the editorial board of that publication?

Dr. Davis. Yes.

Senator Donnell. Where does this Committee on Research in Medical Economics receive its funds?

Dr. Davis. By grants from foundations. The original grant was from the Rosenwald Fund; and the committee had since received grants from the Albert and Mary Lasker Foundation, as well as the Rockefeller Foundation, which has supported the committee.

Senator Donnell. This committee of 13 is the one to which the $165,000 grant was made by the Rosenwald Fund; is that right?

Dr. Davis. Yes.

Senator Donnell. Now, the report that was issued by this health program conference—did that disclose anywhere, do you know, how many members there are of the Committee on Research in Medical Economics?

Dr. Davis. I do not think it contained a list of the members of the committee. The report had been prepared under the auspices of the committee.

Senator Donnell. Did the report state how many persons were included in the health conference?

Dr. Davis. A list is printed on the front page of the report.

Senator Donnell. That list of the 29 names appears under the words "Report of the Health Program Conference"; is that right?

Dr. Davis. That is right.

Senator Donnell. Is there anything in this booklet entitled "Principles of a Nation-Wide Health Program" that indicates to the reader whether or not the health program conference was confined to those 29 persons or possibly included other persons?

Dr. Davis. I do not think any statement is made that other persons were included, but it gives a list of the 29 people. The names are all printed in several places in that report, and there is no statement that anybody else belongs to it.

Senator Donnell. And on the flyleaf of this publication appears this language, does it not:

> This report, by its 29 sponsors, is published with the cooperation of the Committee on Research in Medical Economics. Through the committee, arrangements were made for the meetings of the conference and of subcommittees, in the autumn of 1943 and in 1944.
>
> The expenses of the conference and of this publication were met by gifts contributed for this purpose. The sponsors acknowledge with appreciation the generosity of these donors.

pon the

ons that
e health
Health
nnected
ean A.
he not?
surance

ter New
s Public

in New
n leave,

r. I. S.
d in the
t?

Mott, of

The Wagner-Murray-Dingell bill had been introduced, and there seemed to be considerable confusion in the minds of many people. We brought together by invitation a group of people who we felt represented a group having expert technical knowledge. We brought them together and had a group meeting of the 29 people. I acted as chairman, and the meeting lasted 2 days.

No persons are more determined in their expressions of opinion than highly specialized people who have profound convictions regarding a certain subject. So the problem of getting an agreement was very difficult. However, we proceeded and did get a statement of principles. No legislation was advocated, but the group did reach an agreement on certain principles which were incorporated in the statement. We thought it was a good statement and one useful to stimulate thinking on the subject.

The Committee on Research in Medical Economics, which had to decide, after the technical group had prepared its report, whether it was in general a sound document for educational purposes, decided it was worth publishing, and it was published. We made it available for those who wanted it. We distributed it to a small list, and others bought it for a nominal fee.

Senator DONNELL. I should like to call attention at this point, Dr. Davis, to this excerpt from page 12 of this report of the health-program conference, entitled "Finances":

> The chief support of a Nation-wide system of medical care should be contributory insurance required by law, with the amounts of payment from employees, employers, and self-employed persons related to the earnings of the contributors, combined with support from general taxation.

I take it from that that the health-program conference, of which you were a member, and to the principles of which you adhered, recognizes the fact that this compulsory plan under the Wagner-Murray-Dingell proposed legislation would be supported not solely from payments of employees, employers, and self-employed persons in relation to their earnings, but would necessitate additional support from general taxation, is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Now, Dr. Davis, I would like to ask you whether you know who it was who prepared or had anything to do with the preparation of a certain booklet issued by the American Historical Association, prepared for the United States armed forces, and issued apparently by the War Department? At any rate the flyleaf contains this in a box:

> WAR DEPARTMENT,
> *Washington 25, D. C., 16 January 1946.*
> AG 300.7 (16 January 1946)
>
> EM 29, GI Roundtable: Is Your Health the Nation's Business?
>
> Current War Department instructions authorize the requisition of additional copies of this pamphlet on the basis of one copy for each 25 military personnel, within limits of the available supply. Additional copies should be requisitioned from the United States Armed Forces Institute, Madison 3, Wisconsin, or the nearest Oversea Branch.

Do you know who had to do with the publication of that particular booklet entitled "Is Your Health the Nation's Business?"

recall the
that. I

pared it?
le to tell

ur atten-
pen.

it open,
ll. You

e best of
ient of a
s, and so
over and
heir gen-
locument
ave been
illing to
beg you

g to bind
, is that

A widely accepted answer to the first two questions was given by the Senate Subcommittee on Wartime Health and Education (the Pepper committee) when it said in its report: The quality of American medicine at its best is very high. Unfortunately, American medicine at its best reaches only a relatively small part of the population."

The other questions—on the stake of the general public in preventing ill health and the role of government in the struggle against disease—are not new ones. Community responsibility for public health has long been recognized in laws and ordinances for sanitation, food inspection, and the prevention of communicable diseases. Does public interest also extend to bringing better medical care of all kinds to more people at less cost? This pamphlet presents some of the most widely discussed program for national health and the arguments pro and con touching them.

What are some of the facts and figures that have made the issues seem too important to be left to private effort or to public-health agencies as they now exist?

In 1935, more than 23,000,000 people in the country had a chronic disease or a physical impairment. In spite of tremendous advances in medical science, the death rate among low-income groups in our large cities is still as high as the national rate 50 years ago. Deaths among mothers and babies could be cut about one-third if all got good medical care.

The fact that struck hardest and startled the public most was the revelation from the selective-service figures that 30 percent of the men of military age were unfit for general military duty.

The gap between what modern medicine has to offer and the kind of medical care people actually receive is usually blamed on two things: People's inability to pay for good medical care under present arrangements, and the way health services are organized.

MODERN MEDICINE COMES HIGH

Modern first-class medical care is necessarily an expensive commodity. Many people cannot meet its full cost regardless of the method of payment. The cheapest medical and dental service compatible with good quality and high standards would probably cost about $150 a year for the average-sized family. But studies of family spending show that most families under the $2,000 level—or about half our population—simply cannot pay a full $150 a year for this purpose. If their medical needs are to be fully met, such people need assistance. As it stands today, people in low-income groups, though they have twice as many days of sickness as the well to do, receive only about half as much physicians' care.

Not only does good medical care cost a lot, but the need for it cannot be predicted. If you can't foretell when illness will strike or how serious it will be, how can you prepare to meet its costs? Many a family able to budget $150 a year for medical expenses is staggered or financially crushed for years to come by the cost of a single serious illness. Moreover, having to pay a fee for the doctor's services is a frightening prospect to people whose incomes barely cover living expenses—so they often put off going to the doctor. Thus they lose the benefits of preventive measures, early diagnosis and treatment, and perhaps have to pay more in the end.

Fortunately, though no one can predict when or how seriously an individual will be sick or injured, the frequency of such ills can be figured in advance with reasonable accuracy for groups of people. These facts led the Pepper committee to conclude:

"The pay-as-you-go or fee-for-service system, which is now the predominant method of payment for medical services, is not well suited to the needs of most people or to the widest possible distribution of high-quality medical care. It tends to keep people away from the doctor until illness has reached a stage where treatment is likely to be prolonged and medical bills large. It deters patients from seeking services which are sometimes essential, such as specialist care, laboratory and X-ray examinations, and hospitalization. Individuals with low incomes, whose need is greatest, are more likely to postpone or forego diagnosis and treatment."

HEALTH, WEALTH, AND GEOGRAPHY

Cost is widely recognized as a barrier between individual people and the medical services they need. Another difficulty is that people in some parts of the country don't have enough medical services at hand—regardless of price or

nt parts
Counties,
ospitals,
ely few.
practice
3 times
ensity of
not only
e has to

e, but in
riking—
hospital
ors or to
ve to go
pay but

rgencies
f a well-
and the
ate hos-
ltimore,
patients

asily ac-
are not
ch team-
s where

Thus leaders of both political parties have followed the demand of farm, labor, and business organizations and of the public at large, as shown in various opinion polls, for an improvement in the way medical care is distributed.

Some professional medical organizations echo the cry. The American Public Health Association, an organization of physicians, nurses, sanitary engineers, and others engaged in public health work, adopted in the fall of 1944 an official policy which states that "a national program for medical care should make available to the entire population, regardless of the financial means of the individual, the family, or the community, all essential preventive, diagnostic, and curative services." The American Dental Association has declared that "dental care should be available to all, regardless of income or geographic location." The American Medical Association, representing the majority of private practitioners and on the record as a conservative professional organization, now recognizes the fact that there is a problem in the distribution of medical care. Up to a few years ago, it often asserted that, except in isolated instances, everyone needing medical care was able to get it, by paying for it or through charity.

What Do People Propose To Do About the Situation?

Although a great many people know that ways must be found so that everyone can secure good medical care more rapidly and pay for it more easily, there is no such agreement on just how this should be done. In particular, opinions vary a good deal on the Government's role in the future of medical care. Some think no further Government activity is necessary. Others think that the Government must play a part, but differ as to how big that part should be. Proposals range from tax support for such limited purposes as school-health programs to a complete national health program paid for through national health insurance and general tax funds.

HANDS OFF, GOVERNMENT

Present governmental activities in providing health services are generally accepted. Each American citizen spends about a dollar a year for control of contagious diseases, installation of pure milk and water supplies, and other public-health services. That dollar is considered a good investment. Though State-supported hospitals for mental illness and tuberculosis are sometimes criticized as insufficient, no one wants them eliminated. Rather, public pressure is for their improvement and expansion. So on through the long list of local, State, and federally supported health services.

Yet, at first, almost all tax-supported service met violent opposition from small groups whose interests were temporarily affected. When, for example, the testing of dairy cattle for tuberculosis as a means of keeping contaminated milk from the markets was proposed, dairymen bitterly opposed it. They said that any such measure would mean political control and regimentation.

Similar protests have frequently come from representatives of the medical profession, who usually oppose the extension of tax-supported health services. In 1944, for example, the governing body of the American Medical Association, while recognizing the need for improved early diagnosis and treatment of tuberculosis, did not favor increased Federal responsibility in this field, and refused to support a bill in Congress extending Federal aid to the States for the control of tuberculosis. Aware that under present conditions over half the patients admitted to tuberculosis hospitals are already in an advanced stage of the disease, most public-health experts considered this bill a vital measure toward the ultimate wiping out of tuberculosis. In spite of the position taken by the American Medical Association, Congress passed the law without a dissenting vote 1 week later.

SICKNESS COSTS FALL UNEVENLY

Ten percent of families bear forty-one percent of costs.
Thirty-two percent bear forty-one percent.
Fifty-eight percent bear only eighteen percent.

The AMA today is strongly opposed to any form of Government-sponsored health insurance on the ground that it would bring political control of medicine and interfere with the personal relationship between patient and physician. For some years, the AMA has held that the intimate bond between patient and physician is threatened or destroyed when the patient himself does not pay his doctor on a fee-for-service basis. Yet the AMA, yielding to public pressure for an easier way of meeting sickness costs, now supports voluntary health insur-

reversal
osals for
inciting
am, sum-

ns' serv-
es. The
es, espe-
ere medi-
is made
nployers.
re which
not gen-
nt years,
ser ship-

or hospi-
Hospital
nong em-
year for
es for a
the past

services.
but have
e, chiefly

farmers,
t 200,000

share of the costs. The second difficulty is that, if voluntary plans charge high enough premiums to cover the costs of complete medical and hospital care, they are so expensive that the lower-income groups, who need this care the most, cannot afford to subscribe.

GOVERNMENT AID FOR SPECIAL PROGRAMS

George Washington was still alive when the Marine Hospital Service for sick merchant seamen (now the United States Public Health Service) was established. Since that day a variety of tax-supported health services have one by one been added to the functions of government. Local and State governments and, to a minor degree, the Federal Government provide funds for a large number of hospitals, public health services, and medical care programs. These funds may be used either to combat particular diseases, such as malaria, tuberculosis, or syphilis, or to give all types of care to certain groups of the population, for instance, veterans, men and women in the Army and Navy, Indians, or the needy.

That such Government programs can be successful in delivering medical service of high quality is attested by the brilliant record of Army and Navy medicine in World War II. Official records of the War Department show, for example, that whereas 8.3 percent of the hospitalized wounded, excluding gas casualties, died in World War I, only about 4 percent died in this war. Although warfare in the fever-ridden tropics meant an increase in the number of men hospitalized overseas for disease, the annual deaths from overseas hospitalized illness amounted to only 6 per 10,000 men, as compared with 128 in World War I. Deaths from hospitalized illness in the continental United States accounted for another 6 per 10,000 men in contrast to 156 in World War I.

Such results are to be explained, in part, by recent scientific developments, like penicillin, the sulfa drugs, use of plasma, DDT, and air-borne evacuation of the wounded. But even these discoveries could not have been made effective without good organization, good direction, good equipment, good doctors, and nurses, and good use of doctors and nurses.

Not all Government-aided medical programs have the enviable record of the Army and Navy, but they have met important special needs. Nevertheless, for the total civilian population, these special programs do not meet other equally pressing needs. There are, and will continue to be, all sorts of proposals to fill in the gaps between existing tax-supported services.

The new tuberculosis control law is a good illustration of how an established State program can be expanded by the use of additional Federal funds. An all-inclusive service of early diagnosis, hospital care, and rehabilitation is being developed from a meager program of treatment.

Venereal-disease clinics in a way fit into State mental hospital programs. Early discovery and treatment of syphilis at a clinic can free from this disease vast numbers who might otherwise end up in mental institutions 20 years later.

Other diseases might be attacked in the same way through use of tax funds. Rheumatic fever, for one, which every year kills more children than all other childhood infectious diseases combined, might be much reduced in amount and severity by a concentrated program of attack.

Government aid will undoubtedly be requested for other special groups of the population. For example, tax funds might be sought to help needy parents provide their children with the medical and dental care recommended by school doctors or to help care for the needy in nongovernmental hospitals.

The necessity for many such special programs is generally recognized. Few attack them as undesirable, yet it is frequently felt that approaching the problem of medical care in this piecemeal fashion, disease by disease or by one special population group after another, is unsound. This approach, it is said, has led in the past to a piling up of agencies having to do with medical care—some local, some State, some Federal. Each has different standards and differing procedures for the patients to go through before securing care and which the doctors must follow before getting paid. Many, such as public city hospitals, are still run as charities which most people use only as a last resort.

Tax-supported services are so scattered and uneven that most people don't even know which ones they are entitled to use or how to go about getting them. Under most such programs, the patient must in effect prove that he is entitled to care not just because he is sick, but because he is eligible to become a beneficiary under some particular law.

As new health programs are added, critics of the piecemeal approach maintain, it is increasingly important that they fit into an organized system and

ealth Asso-
ries to be

ne field of
eaded by a
ments and
me of the
y, form a
el that no
Confusion
result of a
say. Until
ot because
n there is
ds of each

others see
re certain
health pro-
o all who

in mind?
nder which
e achieved.
(APHA),
physicians,
These are
a national

directed largely in each individual community and State, and the program should be responsive to local needs. Strictly medical matters must be kept in the hands of the medical profession, which alone is competent to set medical standards, they say, and questions of public concern, such as financing and distribution of services, must be in the hands of the public.

Concluding that a wholly satisfactory health program must be Nation-wide in scope, the APHA and the Health Program Conference reports go on to outline what seem to them the essentials of any such plan.

WHAT ARE THE PILLARS OF A NATIONAL HEALTH PROGRAM?

Five key pillars are necessary to support national health, according to these reports. They are: (1) distribution of the costs of health services, (2) establishment of hospital and public health facilities, (3) organization of medical services to promote a high quality of care, (4) administration satisfactory to patients and the professions, and (5) promotion of continued scientific research and education.

DISTRIBUTION OF COSTS

Starting out with the twin assumptions that the present individual pay-as-you-go method of meeting medical costs has proved itself unsuited to the needs of the population and that voluntary insurance is too limited in scope, advocates of a national health program recognize two alternative ways of meeting medical costs. Both methods of payment are based on the fact that while individuals can never predict when they will be sick or how expensive their illnesses will be, the expected incidence of illness for large groups of people and its costs can be fairly well determined. By chipping in regularly to a common pool amounts which are fair in proportion to his income, each member of the large group can be sure that there will be funds to pay for his own health needs, whether large or small, whether they occur next year or tomorrow.

The first alternative is a system of national health insurance, combined with support from general tax funds. This method is advocated in both reports. National health insurance is no new thing, in fact it is in operation in 31 nations. In some it is over 50 years old. It works like this: Employed people turn in a certain part of their wages each month, through pay-roll taxes, to a government-administered health-insurance fund. Employers match the amounts each worker puts in, as under Social Security in the United States. When sickness strikes the wage earner or his family, doctor and hospital bills are paid out of the insurance fund.

Insurance of this type was designed originally for the wage earner, whose premiums can be easily collected through pay-roll deductions and for whom employers can also make their contributions easily. Such health insurance in other countries has seldom been available to farmers, people who run their own small businesses, domestic servants, and other similar occupation groups. Health insurance on this plan does not touch the sickness costs of nonworking people—the unemployed, the aged, the chronically ill. For this reason both the APHA and the Health Program Conference reports recommend that, if national health insurance is adopted, it be supplemented by general tax funds to include all groups of the population.

The second alternative method of financing, suggested by the APHA, is that the insurance features be forgotten and public health services be paid for simply and solely out of taxes—just like public schools. This, it is argued, would involve far less red tape. All groups of the population would pay for their health services by the same kind of taxes. The amount would vary according to the particular circumstances of the individual. Great Britain, which has had national health insurance since 1911, is planning a system in which two-thirds of the costs will be financed through general taxation along these lines.

Whichever may be the better way of enabling people to pay for medical care—whether by health insurance combined with taxation or by taxation alone—the reports of the APHA and the Health Program Conference agree that as long as payment is made in the manner of today, the "right to achieve and enjoy good health" will not be truly available to all, and that some such Nation-wide solution must be found for the problem.

But a method of paying for medical care is only part of the story. With a thousand dollars in his pocket, a man on a desert island with no doctor or hos-

es in areas
re they are

A hundred
ten only to
get modern

od medical
recognized
t it is also
an attract.
ell-equipped
ey have so
n.
lf as many
evel which
als directly
a national
ct, enlarge,

tresses the
. At pres-
lepartment.
s to insure
nicable dis-
ch as those
eal disease.
t should be

Working in groups, doctors are to some extent supervised by each other in the kind of services they render. For example, a young surgeon in a group is usually assisted by a more experienced colleague when undertaking an especially ticklish operation. The story leading up to the death of any patient is reviewed at staff meetings. These supervisory practices are not a new idea; they have been used for years in good hospitals to safeguard the quality of medical service, especially for ward cases.

Such supervision does not require an outside Government inspector. Under any health program it could be carried out, as at present, by groups of physicians themselves. Indeed, as mentioned before, group medical practice is no new idea, but a familiar phenomenon in the private group clinics scattered throughout the United States, particularly the Middle Western and Western States. What is new in the Health Program Conference report is the idea of encouraging this type of organization throughout the Nation, and combining it with a more favored place for the family doctor than exists now either in individual or in certain types of group practice.

A NETWORK OF HOSPITALS

Towns and cities of different types, sizes, and locations naturally require different sized hospitals and differently equipped hospitals. The country hospital, for example, could never make enough use of radium to justify the expense of owning it. A thinly populated area may need a highly trained brain surgeon only once or twice a year. Nevertheless, when these and other unusual services are needed, they must be accessible. What is the answer?

Both reports endorse a plan of organization somewhat similar to that of Army hospitals. They would encourage future construction of hospitals according to an integrated scheme of health centers (corresponding to the Army field station)—rural hospitals, district hospitals, and base hospitals.

To illustrate: A State might have one or more base hospitals, preferably connected with medical schools, where all types of medical service would be available and where the more unusual types of treatment would be carried out. Here, where they could answer any need in the State, would be the brain surgeons and the radium. Base hospitals would also be centers of teaching and medical research.

The many district hospitals, located in large towns or cities, would be large, and equipped to handle the more usual medical and surgical cases. Smaller rural hospitals would be far more numerous than at present and would be designed to take care of ordinary diagnosis and treatment, minor surgery, obstetrics, and so forth. They would refer complicated conditions to the district or base hospitals. Health centers, spotted about hospitals of all types, would house the offices of public-health nurses, laboratories, public-health clinics, doctors' offices, and some emergency beds.

Patients would, as a rule, go to the hospital nearest home, but for particularly difficult types of diagnosis or treatment might go to a base hospital, much in the same way that those who can manage it now go to a well-known clinic or medical center.

This scheme of integrated hospitals would make constant exchange of information, training, and personnel among them possible. On this foundation, a consultation service could be built so that at regular intervals specialists from the larger hospitals would visit rural hospitals and health centers. At the same time, rural physicians might go up to the base hospital for special postgraduate training, returning to their practice stimulated and better prepared.

Proponents of a Nation-wide health program see in hospital organization along these lines a tremendous inducement to physicians to organize themselves into strong professional groups. Whether or not doctors would wish to take advantage of these opportunities would, of course, remain to be seen. There are indications that younger members of the profession, in particular, would welcome the chance.

ADMINISTRATION

How could such a program be carried out so that both the patients who receive the services and the doctors, dentists, nurses, hospital people, and others who render the services would be satisfied? Here, the guiding principle, both reports agree, is that while the health program should be national in scope and while certain national standards are necessary to insure that public funds are used ning and

al health
minimum
t be simi-
aboratory
subject to
l.
ould have
nities and

under the
raditional

organized
be free to

tients; to
ervices as

participate
ies and re-
ticipate in

fers a pat
agree that
with high
should be

funds must be forthcoming where private funds leave off if knowledge is to march steadily forward. In fact, during the war, the Federal Government sponsored and in many cases subsidized both medical and nursing education and a variety of scientific research. The results—for example, discoveries as to the processing and uses of stored blood—are familiar enough to those in the armed forces.

In addition to funds for research, the Health Program Conference report emphasizes the need for more opportunities for postgraduate training for physicians. Medical science advances so rapidly that the physician who graduates from medical school this year will find it necessary next year to bring himself up to date. Too often the busy practitioner has no time to keep up with advances through study and reading; rarely is he in a position where he can afford to take a month off for postgraduate study. This is particularly true of the country doctor. Opportunities for doctors to get postgraduate medical education could be greatly furthered by the use of public funds, advocates claim, although even more important day-by-day results would be obtained through improved organization of medical services.

THE OSRD REPORT

The use of Federal funds to support a program of scientific research was recommended to President Truman in July 1945 in a report of Dr. Vannevar Bush, director of the Office of Scientific Research and Development—the Government agency responsible for the use of Federal funds for such research during the war.

In this report the war against disease is given first consideration. Dr. Bush strongly advocates Government support of medical research as basic to any national program of expanded medical training and research and to the promotion of public health.

The report, which recommends the establishment of a national scientific research foundation responsible to the President and Congress, was received with widespread public interest.

Has a National Health Program Been Put Before Congress?

Do these principles of a national health program appear in practical form in the legislative proposals brought before Congress? What manner of national health program is it anyway that has been advanced for public discussion and eventual congressional decision?

Beginning in 1943 with the original Wagner-Murray-Dingell bill to add health insurance to the social-security system, several bills have been proposed embodying the principles. They include the Hill-Burton hospital-construction bill, a new version of the Wagner-Murray-Dingell bill introduced in May 1945, and a still later revision of November 1945.

THE FIRST WAGNER-MURRAY-DINGELL BILL

National health insurance was but one of several provisions of this bill. Other provisions, such as extension of social security, the nationalization of unemployment compensation, and Federal aid for general relief, are beyond the scope of this discussion.

The bill provided that health insurance would be established by the creation of a national medical-care and hospitalization fund, to which employers and employees would each contribute 1.5 percent of the first $3,000 of annual wages, making 3 percent in all. Self-employed would contribute the entire 3 percent themselves. Contributions amounting to an additional 4.5 percent of wages would be made by employers and employees, 9 percent in all, to pay for the other benefits of the bill. Two of these latter provisions have an important bearing on health, namely, those providing for cash payments during temporary and permanent disability.

For every insured person and his family, the medical care and hospitalization fund would pay for unlimited doctors' care, including specialists, for hospitalization up to 30 days, X-rays, and laboratory tests. Dental care, nursing, medicines, and drugs would not be paid for.

Patients would be free to choose their physicians from among those participating in the program, whether engaged in individual or group practice. Standards of competence for specialists and hospitals would be established by the Surgeon General of the United States Public Health Service. Any licensed physician could participate in the program as a general practitioner.

The national fund would pay physicians for the services rendered to patients covered by the system through any of several methods—fee-for-service, capita-

The
f payment
y for each

ess. Nev-
organized
ormous an
esponsible
ipport it."
organized
on groups
a doctor
ses would
the doctor
competent
. Largely
a quarter
emes were
on its gau-
General of

to boycott
ing physi-
bill passes
you don't
are going
rance, you

proposed

2. Increased grants to the States for public-health services and maternal and child-health-care programs.
3. Support of medical education and research.
4. Expansion of compulsory insurance under the social-security system to cover medical, hospital, nursing, laboratory, and dental care.
5. Cash benefits to cover some of the wage losses during periods of sickness and disability.

In order to meet, at least in part, the President's request, Senators Wagner and Murray and Representative Dingell promptly lifted, rewrote, and introduced as a separate bill the health provisions of their earlier measure.

These health provisions include, besides medical-care insurance, increased Federal grants to the States for public-health work and for the care of mothers and children, but no funds for construction of hospitals and health centers. Benefits of the medical-care insurance have been increased by adding limited home nursing and dental care. An attempt has been made, too, to increase the responsibility of States and communities through advisory committees, although the final administrative control remains in the Federal Government. Court review of administrative decisions is, however, specifically authorized.

Groups of physicians, as well as individual practitioners, may participate in the plan, but they are not expressly encouraged. The physcians of an area may still decide by vote how they wish to be paid, but such a vote is no longer binding upon all the doctors of the area. General taxes are to be used more generously to supplement the funds contributed by employers and employees, but the plan does not yet cover the entire population.

SUMMARY OF OPINION

Discussion of national legislation for health will doubtless be focused about the Truman proposals and the latest Wagner-Murray-Dingell bill for some time to come. It will be useful, therefore, to repeat the principal arguments for and against the original bill. The groups supporting the 1943 measure emphasized the necessity for Nation-wide action in order to equalize the opportunity for health services among all groups of the population in whatever part of the country they happen to live. They also stressed the need for a method of paying for medical service by which people can pay in known, regular amounts, month by month, in accordance with their earnings.

Those opposed to the first bill, on the other hand, made an issue of the danger of political control over medical matters, of a possible threat to the individual freedom of patients and doctors, and of the limitations that it might impose upon physicians in professional status and—by implication—income.

The Nation-wide discussion that took place as a result of the introduction of the bill had broad educational value. It stimulated people everywhere to greater awareness of the issues. It provoked painstaking inquiry by numerous nonprofessional organizations and groups as to the true facts of medical care in their own communities and in the Nation as a whole. All this served in some degree to clear the air, to dispel false notions and groundless fears, and to aid the country in facing realities. With this increased interest and knowledge as a background, the public is better prepared, with the introduction of the November 1945 bill, to resolve differences of opinion and to focus its attention upon specific points for action.

THE HILL-BURTON HOSPITAL CONSTRUCTION BILL

This measure, introduced in the spring of 1945, would provide Federal grants to States for the construction of hospitals and health centers. Designed to encourage over-all planning by the States of an ordered network of health facilities, the bill calls for each State to study its existing hospital resources and unmet needs, in order to develop a master plan of construction. The Federal Treasury, after State plans had been approved by the Surgeon General of the United States Public Health Service, would supplement funds for construction raised within the States, paying a larger share of Federal funds in poorer States, and a smaller share in richer ones.

Besides providing for the construction and improvement of State, city, and county hospitals for general care, mental illness, and tuberculosis, this bill would also aid in the construction of thost nongovernmental community hospitals which are not operated for profit.

rm groups,
opposition.

ties might
e costs of

s is made
sh to avail
based on

to general
stances of

lividuality
ion of im-

ps because
great deal
at present,
composed

meet only
d hospital
munity if
is the sad
to popula-
used. In
pitals, the
t arrange-
nts, in the
mmunities

Finally, the report urges postponement of the consideration of "revolutionary changes" while large numbers of men and women, including medical officers, remain in the armed services, and proposes measures for rectifying the present and future shortage of medical personnel, particularly in rural areas. The question of the organization of medical services around a network of hospitals, or in group practice, is not touched in this report.

WHAT ARE THE MAIN ISSUES?

Public discussion in recent years indicates widespread concern about the quality and distribution of health services in the United States. Five principal problems are generally recognized:

1. How to arrange payment so that all the people can regularly pay specified amounts in accordance with their earnings rather than be burdened irregularly and unexpectedly with the large costs of unpredictable illness.
2. How to pay for medical services and facilities so that they can be available more evenly throughout the country.
3. How to organize America's health services to use our medical resources most effectively and furnish service of high professional quality.
4. How to make necessary changes and yet preserve the best of our present medical practice, avoid undesirable and arbitrary governmental controls, and guarantee freedom within the program for both patients and physicians.
5. How at the same time to stimulate continued and improved medical education and research.

Although there is much disagreement as to how it should be done, most groups of the professions and the public appear to agree on the basic principles that people can more easily pay for medical service by some type of insurance than by the traditional fee-for-service method; that Federal funds from general taxation will be needed if hospitals and other facilities are to be built in needy areas; that medical services can be supplied more economically and with better guaranty of quality by the use of group medical practice than by individual practice; that local representatives of the professions and the public must control the distribution of services on the basis of broad national standards; and that national funds will be needed to support improved and extended medical education and research.

Controversy has been most pointed about the proper role of Government in any changed organization of health services. Opinions range from those who would limit Government aid to specific problems—such as sanitation, communicable disease control the care of the needy, institutional care for mental illness and tuberculosis—to those who would have Goverment, particularly the Federal Government, take steps to assure adequate health and medical services to all.

TO THE DISCUSSION LEADER

Every human being is faced with the problem of his own personal health. The head of a family has the added responsibility of looking after the health of his wife and children. Civic-minded individuals recognize that health is also a community concern—that good health for the individual often depends on improving health conditions and health standards for the community.

This pamphlet presents major points of view on the important question of improving health. It does not try to give an answer. That is something for the individual to think through for himself.

It is doubtful whether any reader of this pamphlet or any member of a discussion group would argue against the improvement of health. Discussion leaders will encounter plenty of conflicting opinions, however, when they raise the question of how health can best be improved. This question of how it should be done is something to talk over at your discussion meeting on the basis of the soundest information available.

HOW CAN YOU PLAN A DISCUSSION MEETING?

Discussions are ideas in action. You cannot have a lively voluntary discussion unless you bring together individuals who are interested in a subject. Therefore, you need two things: A subject that will interest some people very much, and a means of letting people know that a discussion meeting is to be held on that subject.

"Is Your Health the Nation's Business?" is a subject that will probably interest many people.

e in your

w a copy
him the
placed on
you have
s arrange
material
who will
o be held
nterested

t type of
oubt you
ision you
ion group
e? What
ps in the
ct?
nd disad-
nposiums,
1, Guide
Below are

excellent
y experi-
d. After
e speaker

itself. It is well, however, to be prepared. Below are some questions which you may find helpful.

1. Has civilian medical care been accessible and satisfactory to members of the discussion group and their families? Has the problem of payment for physicians' care or hospitalization been difficult? Have doctors and hospitals been located reasonably near at hand? Has it been easy or difficult to obtain the services of necessary specialists? Why?
2. Would the problem of payment for medical service be eased by insurance against the costs? Do you think voluntary insurance against the costs of sickness can provide a satisfactory solution for the problem of payment throughout the country? In urban communities? In rural areas? In all geographical areas?
3. Would there be professional advantages in a scheme in which physicians practiced in groups? Economic advantages? From the patient's point of view? From the doctor's point of view?
4. How do the advantages and disadvantage of medical practice in the military services compare with those of present-day civilian medicine? From the patient's point of view? From the doctor's point of view?
5. Is the normal peacetime distribution of civilian physicians and hospitals satisfactory? What factors influence this distribution the most? Could they be modified by physicians? By the public? How?
6. What measures have recently been proposed by the American Medical Association to meet the Nation's health needs? What effect do you think these proposals, if carried out, would have upon (a) the ability of people generally to pay the costs of sickness? (b) The distribution of doctors' and hospital services? (c) The quality of medical and hospital services?
7. Do you think the United States Government should (a) do nothing further in the health field? (b) Support only special health programs such as those to benefit mothers and children or combat venereal disease, tuberculosis, and mental illness? or (c) sponsor national action for health care on a broader basis by insurance or tax support? Would action by the Federal Government tend to improve or lower the quality of medical care received by people generally? Why? Would most doctors benefit or suffer economically and professionally as a result of Federal action? Why?
8. Should the Federal Government aid in the construction of hospitals where they are needed? How should such hospitals be supported if built? Who should own them? Who should determine their location? What doctors should be eligible to use them? What patients should be eligible for admission to them? Would hospitals built without Federal Government aid serve the public better?

Senator DONNELL. Now I want to ask you this, Dr. Davis: During the last 10 years—that would be from 1938 on down to this time—you have been very closely associated with, among other persons, these three gentlemen: Dr. Thomas Parran, Surgeon General, United States Public Health Service; Dr. I. S. Falk; and Mr. Watson B. Miller; is that correct?

Dr. DAVIS. To varying degrees of closeness; yes.

Senator DONNELL. And you have consulted frequently with Dr. Falk on the question of compulsory health insurance, have you not?

Dr. DAVIS. Yes.

Senator DONNELL. And you and he, Mr. Miller, and Dr. Parran have together conferred on that subject from time to time?

Dr. DAVIS. I don't recall attending any conference at which all those people you have named were present at one time. I may have been.

Senator DONNELL. Doubtless that was an inaccurate question. You have conferred separately with each one, or possibly with one or more at different times; is that right?

Dr. DAVIS. Would you care to have me enlarge upon that at this point? I might make a very brief general statement which would cover perhaps the point that you seem to be interested in.

Senator DONNELL. That would be all right.

noment.
ong time
l things
people's
mber of
ped only
a private
to help
he condi-
ery little

and the
ame con-
-did not
did not
fact that
her they
nily, and
nder the
ew years

out what
oluntary
came in-
I went

to make an audit of improving the quality of medical services rendered in a large city.

From then I got into consultation work, which took me over the country, and I also had occasion to go abroad several times, sometimes at my own expense, sometimes for an organization, to study the situation of health insurance abroad.

I became gradually convinced of what was needed in this country, but it was not until very recently that I was prepared to come out for national compulsory health insurance. I discarded the voluntary plans, I discarded the purely State system grant-in-aid plans, and finally I became convinced that we had to go as far as, I would say, this bill, with various modifications which I would be glad to discuss.

But this bill in principle seems to me to be about the thing that we need to do for the people of this country. I recognize that in the minds of many people, even outside the medical profession, it is considered to be too big a step to take at once. But I am not afraid of the United States taking big steps. We have taken a good many big steps at different times. One of the things Americans are justly proud of is the fact that they are not afraid of doing things.

So in substance I have tried to give a brief history as to how I gradually became convinced that in the interests of both the people of the country and the doctors themselves a comprehensive system of health insurance, supplemented by necessary taxation for certain purposes, is desirable and necessary in the United States, and we ought to have it just as soon as possible.

Senator SMITH. Do you think, Doctor, that the whole existing system ought to be changed then, that we should make an over-all change of existing methods in the handling of the health problem? I can see you have given your life to that; it is a crusade with you. And you believe that this extreme change should be made?

Dr. DAVIS. Senator, I do not consider that this bill would change our basic system in its most fundamental respects.

Senator SMITH. I thought you said the existing system was wrong?

Dr. DAVIS. With respect to the way the doctor is paid by the patient, yes; but not in the way that medicine is practiced.

Senator SMITH. It is just a question of the way he is paid?

Dr. DAVIS. Yes; that is the fundamental change that I see necessary. I regard the development of a better technique of organization in medicine through group practice as necessary, but I feel that you cannot legislate group practice. You have to educate and encourage people, and remove obstacles to set up the kind of an organization that would make group practice easy.

I think those obstacles are rather detailed, but the big obstacle to group practice is that the average doctor has been trained in his private practice to individual work, and he takes group practice as being something rather difficult.

This illustrates my point. I have a friend who lives in Philadelphia, a layman, who is chairman of the board of a large hospital. They have a medical staff of 150 doctors. He has a brother who is a member of the board of directors of the Philadelphia Symphony Orchestra, and my friend has told me that there is one subject on which he and his brother endlessly debate without ever coming to any definite conclusion, the subject of the debate being: Which is the most difficult ysicians

ne of the
asure of
fear and
st degree
tion of a

complete
n all the
tax—to
ange.
inion on
compre-
ike Cali-
ning out
State to
e asking
national

ation to
Governor

mends a

comes in, and I am sympathetic to the resistance because I think you are asking for the complete turn-over of a whole social system, by putting everybody completely under this umbrella of social security.

You might very well say, "We will have a fund set up and charge them on the pay roll, and then when they are sick we will give them money to take care of their health needs. The other thing that might be contemplated is having the Government guarantee the service. That means that you have to put your hand on the medical profession and the hospitals, and everything else, and say, "We have to be able to organize this in a way to give value received for the taxes imposed on the individual who pays for the service." And that is a very much more drastic thing than simply saying we will have a fund set up and when a person is sick we will give an allowance to take care of that.

Dr. Davis. May I comment on that?

Senator Smith. Yes. I want to see what you think about it.

Dr. Davis. First may I comment on the cash benefit, the so-called indemnity benefit, by giving people cash? I have had an opportunity to observe that sort of scheme, and I do not think there is enough of value in a strictly indemnity or cash payment plan to provide for a neighborhood patient to pay his medical bills to justify much good to bring it about. I think there is no guaranty of medical service. There is very strong insistence on the part of most medical societies that there must be an income limit above which the physician shall be free to charge the patient any amount they may agree upon on the usual fee basis.

The other point you raise seems to be a very real point, which I regard as the toughest nut to crack, namely, the problem of passing a law like this and putting it into effect on a sufficiently comprehensive scale, and rapidly enough, to enable the Government, which is taking in money from people by law, to deliver the services which are involved in the law. I think that is the point you have in mind.

Senator Smith. That is correct.

Dr. Davis. My answer to that and my justification for recognizing the nature of that problem while nevertheless favoring this law, is this: In the first place we have to consider the medical service which people receive in terms of a practical standard of comparison as between what people in a given community and in a given walk of life have been accustomed to get and accustomed to expect; and we must not expect that everybody is going to receive at once the same kind of service which a well-to-do person in a large city can now command when there is no economic barrier, and he has intelligent advice and guidance in selecting his doctors and hospitals.

We have to proceed on a practical basis. We also find in practice that the lack of sufficiently intelligent demands on the part of many people for medical service is a barrier to good medical care, and that is also one of the very important reasons why it is practicable to put this law into effect, because demands on the part of the people do not suddenly jump from nothing or from very little medical care because they have not been accustomed to having it except in emergencies, to a volume of medical care corresponding to that which good professional judgment would call adequate. It works up slowly.

Senator Smith. You will have to admit that if you are going to deduct a certain amount of money per week from a person's pay roll

educted,
t bit ill,
doctors
nd then
t unless
ation so
rtake to

ratively
and the
aw, that
as been
ch they
e would
hey are
e in the
ve been

enough
services
1320, if
ve testi-
years to
cting in
deliver.

have to have a good deal of Government supervision with respect to those vacuum areas, whether State or Federal. It would have to take a lot of thinking and blueprinting to set up a system that would meet the obligation undertaken by the Government if such a law were passed.

Dr. DAVIS. May I make one comment on that to illustrate the way I think it would work?

Senator SMITH. Yes.

Dr. DAVIS. This bill provides for a State survey preliminary to the formation.

Senator SMITH. So does S. 545.

Dr. DAVIS. Yes; both bills do.

Now, under S. 1320 those State surveys require that the State shall find out what the shortage spots are, and what the needs are, and to be able from the fund—when the fund becomes available after taxes begin to be collected, when the allocation of that becomes available—to take the steps permissible under this bill, through the State agency and not by the Federal Government, to try to set up inducement which will induce doctors to go into those areas.

Senator SMITH. And it is your testimony that there are plenty of doctors today—that there are enough doctors today—to carry out the program under S. 1320?

Dr. DAVIS. My opinion is this: I do not agree with the American Medical Association that we do not need more doctors, Senator, but I think the problem of redistribution is the most important factor in connection with the problem of increasing the supply, and my opinion in connection with the problem of increasing the supply of doctors is that the rate of increase in demands on the part of the population under the universal prepayment system would not be so rapid as to embarrass us. We should take steps to catch up, but I feel that that is of secondary importance.

Senator SMITH. Your testimony is in direct conflict with that of other sponsors of the bill who think that we are woefully short of doctors, and that the first thing to do is increase the number of our medical schools. It takes 10 to 12 years to educate a doctor properly, you know.

Dr. DAVIS. Even though I do not think that we are so short, I am very much interested in developing a plan to educate more doctors.

Senator SMITH. There has been so much evidence that there is a shortage of doctors, dentists, and nurses that I think we ought to do something to build that army up. And I feel sure that you will admit that it is one of the difficult problems we have confronting us. I won't dwell on it any longer.

Senator MURRAY. Before we leave that point, could I ask one question?

Senator SMITH. Yes.

Senator MURRAY. In the present situation of the distribution of medical practitioners, is it not a fact that many doctors are practicing in locations where they are not fully occupied and are not making an adequate income? Is that true?

Dr. DAVIS. Yes, sir. I would say that is true. There are two great sources of additional medical manpower. One is the young men. I would say that in the first 5 years of the average young medical man's tice—at

ke their
ence in

ct with
ssistant,
es more
der doc-
act that
to give
ower of
r man's
e.

ou that
with an
e spoke
with an
r assist-

Iurray's
money,
e in the
course,
incom-

Senator Donnell. Dr. Davis, I want to ask you a few questions about some matters here, and then I want to ask you a few questions about some observations of yours on the bill.

Senator Smith. Would you rather adjourn until tomorrow morning? It is getting rather late.

Senator Donnell. I would rather finish now, if I could.

Senator Murray. I had one or two more questions to ask Dr. Davis, but I'm sorry to say that I won't be able to remain. I have an engagement.

Senator Smith. Would you like for Dr. Davis to come down tomorrow?

Dr. Davis. I'm sorry, Senator.

Senator Murray. If I could ask him just one more question here, I'll be satisfied.

Senator Smith. Can you wait with your questions for a moment?

Senator Donnell. All right.

Senator Smith. Go ahead, Senator Murray.

Senator Murray. You have gone into rather considerable detail in listing a number of organizations that you have been connected with. Were these organizations all devoted to an honest and careful study of the problem of finding a manner in which we can bring about the better distribution of medical care in this country?

Dr. Davis. Yes, sir. My interest is not in any other kind of organization. I do not want to be associated with any other kind of organization.

Senator Murray. Another witness testifying here before this committee said that he would like to see a situation in this country where the relative merits of these bills would be honestly and openly discussed in the country. Are you familiar with the National Physicians' Committee, Dr. Davis?

Dr. Davis. Yes, sir.

Senator Murray. Is it devoted to an honest, open study of the problem that we have been discussing here this afternoon?

Dr. Davis. I would not consider that it has been, and I would like to say this further about it. It has been a source of very great regret to me that physicians, who are individuals of a very high standing in their profession and have a great deal of devotion to their patients, have been willing to lend their moral and financial support to the National Physicians' Committee, because I feel in the main that the National Physicians' Committee can be characterized thus: A group of physicians constituting its governing board of trustees have been prepared to turn over the conduct of their public relations to a group of men and women whom they have employed as their staff and who have been skilled advertisers and public-relations salesmen in the technical sense of those words, and who have absolutely no regard for intellectual honesty or for fairness in dealing with opposing views. And it seems to me very tragic indeed that the compulsions of fear and anxiety have led a number of physicians to support an organization whose staff has been characterized in the way I feel it is necessary to characterize it.

Senator Murray. Have you seen any literature that has been sent out across the country by the National Physicians' Committee?

Dr. Davis. I am not on their mailing list, Senator, for reasons which apparently are fairly obvious, but in view of the fact that

think I
, I might

y present
ing here?
the Wag-
rs, gotten
acterized
of appeal
has pre-
o are the
the Na-

National

Will W.

he South-
r? I am
nittee.
Mr. Alex-
al Action

Dr. DAVIS. No, sir.

Senator DONNELL. Have you ever seen such data as I show you here: "Medical Insurance, A Pathway to Health. Narration for Filmstrip. Copyright 1947 by Current History Films, 77 Fifth Avenue, New York 3, N. Y."?

Dr. DAVIS. I'm not sure. If I can glance at it I may be able to tell. I have seen one film strip.

Senator DONNELL. I will show you one thing that may refresh your memory.

Dr. DAVIS. You see, I get a good many things of this kind to look at.

Senator DONNELL. I would like for you to notice this acknowledgment at the top of this page:

> We wish to asknowledge with thanks the generous assistance and cooperation of the staff members of the Committee for the Nation's Health in supplying data and valuable advice.

Does that refresh your memory?

Dr. DAVIS. Let me see. Yes; I think I recall. This is a film strip, not a movie. It is a film strip. The people came to us and asked us to review the script which was to accompany a film strip. They had prepared the films, and they had prepared a script. They asked us to review the script as to its accuracy, as I recall.

Senator DONNELL. Did you review it as to its accuracy?

Dr. DAVIS. Yes, sir.

Senator DONNELL. Did you approve it as to its accuracy?

Dr. DAVIS. I have not personally read the script since it was in final form. That is why I did not recall it. When I first read it there were several suggestions I had to make to correct defects in it. I have never read it, that I recall, since it was in its final form.

Senator DONNELL. Did you make any suggestions that you thought would make it more accurate and correct?

Dr. DAVIS. Yes.

Senator DONNELL. Do you remember what suggestions you made?

Dr. DAVIS. I couldn't say that.

Senator DONNELL. How long ago was it that this film-strip narration was presented to you for your consideration?

Dr. DAVIS. I should say something like—well, it was within the last 10 months, I should guess.

Senator DONNELL. Who are the staff members of the Committee for the Nation's Health referred to in this acknowledgment?

Dr. DAVIS. The committee has only a small staff. Mr. Joseph H. Louchheim.

Senator DONNELL. He is the gentleman who testified before you today?

Dr. DAVIS. Yes. He is executive director. And myself in New York. Miss Margaret I. Stein is our Washington representative, with headquarters here.

Senator DONNELL. She is the lady who is here in this room this afternoon; is she not?

Dr. DAVIS. Yes; I see her here. And we have had a public-relations man. At the moment I think we have none, because we are just changing, but I think we have had a public-relations man.

I might add that my own time I give without compensation. I give about half of my time to the Committee for the Nation's Health,

n going
contacts,

heim, and
reference

t came to

York?

uchheim?

ed in the

narration

I think it
about us.
re in the

nguished

o you can
ures run

the number "85." And included in this film-strip narration, after various preliminary things—I will offer this entire document in the record in a little while—is this language, at No. 30 to No. 32 and following:

> 30. How can this barrier be broken down? How can the economic separation between patient and doctor be closed so that all people, in all income groups, may receive the medical care they need and must have for good health and a happy life?
>
> 31. The most important proposal yet made for bridging this economic gap is a system of prepared national medical insurance.
>
> 32. Such plan is contained in the much discussed and controversial National Health Insurance Act. What is in this act? How would it work? That is what we will see next.

Now, Dr. Davis, what insurance act is referred to in that text?

Dr. Davis. It referred to this act.

Senator Donnell. To S. 1320? Or its predecessor, S. 1606, the Wagner-Murray-Dingell bill of last year?

Dr. Davis. Yes.

Senator Donnell. Quoting further from this film-strip narration:

> 33. National health insurance would work very much like life insurance. Individually, most of us could not provide life insurance for our dependents. Collectively, we can. Each of us pays a small premium into a common fund held by an insurance company. When the need arises the insurance is drawn from this collective barrel. We call that the principle of sharing the risk and spreading the cost.

Then, after an observation in frame No. 34 on fire insurance [reading]:

> 35. That is the idea of national health insurance. Everyone covered by the plan would pay a small premium into a national fund to be used solely for medical care. Like any other insurance, it would operate on the principle of sharing the risks of illness and spreading its cost over millions of people. Since this is a national problem, instead of having this protection operated by a private company, it would be handled by an agency of the Federal Government.

Do you remember, on reflection, the fact that those observations were contained in this film strip as submitted to you?

Dr. Davis. You have read them.

Senator Donnell. Do you remember them?

Dr. Davis. I recall.

Senator Donnell. And you understood that the primary purpose of this film strip was for educational purposes, to be sent out to schools all over the country to serve in an educational capacity; is that right?

Dr. Davis. Yes.

Senator Donnell. And you thought it would have very considerable value in that connection, I assume; is that right?

Dr. Davis. I was not greatly impressed by its value, inasmuch as small film strips are usually pretty unimpressive. Young people accustomed to the beautiful technique of the modern motion picture are usually not much impressed. I was not much impressed by it except for use in classes, as distinguished from general audiences. General audiences are not impressed by the poor technique that is apparent in most small film strips.

Senator Donnell. Were you told whether it was going to be used at all for public audiences?

Dr. Davis. I think this firm, as I recall, wanted to sell it. I was not greatly impressed with its possibilities. I do regard the use of any

d I so
as an

ing to

that a

s film-
owing:

44.
rogram
ay, New

le ago.

Ameri-
ecember

Depart-

ago to
he fly-

ditional
rsonnel,

that is the bureau with which Mr. Falk is connected; that is correct, is it not?

Dr. DAVIS. Yes.

Senator DONNELL. I call attention also to the fact that it is stated in this document here that I offer in evidence with respect to this narration for film strip, as follows:

> Photos used in this film strip are from the Library of Congress, Federal Security Agency, United States Public Health Service, Farm Security Administration, OWI—

that is the Office of War Information—

> and Underwood & Underwood, New York City Public Library.

Now, Mr. Davis, you readily gave the desired cooperation by looking this over, did you not?

Dr. DAVIS. Yes.

Senator DONNELL. The address of Current History Films, by the way, which is mentioned here on this publication, is 77 Fifth Avenue, New York City, is it not?

Dr. DAVIS. I don't recall it.

Senator DONNELL. That is the address on here. Now, do you know that lodge 500 of the International Workers Order at 80 Fifth Avenue is directly across from 77 Fifth Avenue? Do you know that to be true?

Dr. DAVIS. I don't know.

Senator DONNELL. But you do know that 80 Fifth Avenue has been used for a whole series of Communist-front organizations, including the Artists League? Were you informed of that?

Dr. DAVIS. No, sir.

Senator DONNELL. I observe that in this film strip it says under frame No. 3, after giving the title in No. 2, "Medical Insurance, a Pathway to Health"—an "ERG Production." Do you know who the persons are for whom ERG stands?

Dr. DAVIS. No.

Senator DONNELL. Did you not know that ERG stands for Mr. Eiseman, Mr. Roberts, and Mr. Goldman, who have been investigated by the Committee of the House of Representatives on Un-American Activities? Did you not know that?

Dr. DAVIS. I did not know anything about it beyond this one fact, Senator. We are a service organization—and I am speaking now for the Committee for the Nation's Health—and we are perfectly prepared to do what we did in this case—render technical information in connection with material that comes to us in good faith when anyone asks for it.

Senator DONNELL. Now, Mr. Davis, you observed that it said in here "Title: An ERG Production"—you saw that, did you not?

Dr. DAVIS. The "ERG" didn't mean anything to me. These people had done a script already. They wanted to know whether, technically, it was reliable. We gave them a review of it.

Senator DONNELL. I offer into the record at this time a paper which represents, so I am reliably informed, and believe to be true, data derived from the report of the Special Committee on Un-American Activities of the House of Representatives, Seventy-eighth Congress, second session, in respect to Messrs. Eiseman, Roberts, and Goldman,

s, is the
am now
3, 1947,
he New

ich con-
oldman,
t of the
of data
I believe

ON

and Gold-

man, pho-

tion and
American
Un-Amer-
cond ses-
on on the

(The document referred to follows:)

MEDICAL INSURANCE—A PATHWAY TO HEALTH

Narration for Filmstrip

(Copyright 1947 by Current History Films, 77 Fifth Avenue, New York 3, N. Y.)

How to Use the Film Strip

Film strips are primarily an educational medium—a visual aid to teaching and learning. They are not intended for relaxation or entertainment. They are not designed to replace motion pictures and are not a substitute for discussion but rather an instrument to stimulate questions and discussion.

METHOD

Know the subject of the film. Read and prepare *beforehand.*

Precede the showing with a very brief introduction which will help *lead* the audience *into* the subject.

During the showing feel free to depart from prepared narration with your own words. Ask the audience questions. Go back to earlier frames to make a point. With some subjects it should be possible to cite *local examples* of what the film shows.

After showing, try to have a discussion period with *questions* and *answers* designed to sum up and emphasize what was seen and heard.

PREPARATION

Rehearse with the film *at least once* before the regular showing so as to become familiar with narration and pictures. This is essential—often makes the difference between good and poor presentations.

Read the material supplied with the film strip kit—it will help you *prepare* and answer questions.

Be certain you have enough light to read the script. A pocket flashlight will often suffice.

Anticipate difficulties. Some well *before* the time set for showing and set up equipment.

Check details. Make sure you have the *proper* projector. A film strip is shown with a 35-mm. *single frame* film strip projector. There are many different types available.

Make sure electric outlet is convenient and that *power* is available at the outlet. If needed, get extension cord.

See that stand or table is secure, in position. See if screen is *in position* and a clear path from machine to screen. (Note: If regular screen is not available use a white sheet or large white cardboard. In a pinch a white or flat light-colored wall will be adequate.)

OPERATION

The film may be *shown* by the same individual who speaks the narration. But—it has been found that if one person operates the projector and another concentrates on the narration—better results are obtained. With such an arrangement, the narrator and projectionist work as a team. Each time the speaker is ready to have the next frame (picture) on the screen, he signals to the operator by tapping lightly with a pencil or other object or by using a flashlight.

Remember! Preparation is 90% of success. (1) Read up beforehand on your subject. (2) Rehearse. (3) Be ready before your audience arrives.

Film Strip Narration

Frame No.—

1. (Title: Current History Films presents.)
2. (Title: Medical Insurance—A Pathway to Health.)
3. (Title: An ERG production.)
   (Start narration.)
4. The most important resource of a country is its people.

llows that

needed to

ined was
ned were
lmost one

nal survey
carry on
cts. This
nents.
horitative
ncrease in
mong the
rrested or

g the best

e colleges

ne preven-

the only
s health—
protection

nomically
ple. The

28. Only 9 percent were receiving regular health examinations. The rest, 9 out of every 10, we repeat, 9 out of every 10 persons in this group, were going along without any medical check-up whatsoever.
29. We know that periodic examinations are necessary to detect an illness before it goes too far. How many young men rejected for military service came from homes which were unable to afford doctor's care? How many of those dead of chronic diseases could have been saved by the routine of early diagnosis and early treatment?
30. How can this barrier be broken down? How can the economic separation between patient and doctor be closed so that all people, in all income groups, may receive the medical care they need and must have for good health and a happy life?
31. The most important proposal yet made for bridging this economic gap is a system of prepaid national medical insurance.
32. Such plan is contained in the much discussed and controversial National Health Insurance Act. What is in this act? How would it work? That is what we will see next.
33. National health insurance would work very much like life insurance. Individually, most of us could not provide life insurance for our dependents. Collectively, we can. Each of us pays a small premium into a common fund held by an insurance company. When the need arises the insurance is drawn from this collective barrel. We call that the principle of sharing the risk and spreading the cost.
34. Fire insurance works on a similar principle. We pay during the time we are secure for future protection. It is possible to do this because thousands of people pay into a common fund and share the common risk.
35. That is the idea of national health insurance. Everyone covered by the plan would pay a small premium into a national fund to be used solely for medical care. Like any other insurance, it would operate on the principle of sharing the risks of illness, and spreading its cost over millions of people. Since this is a national problem, instead of having this protection operated by a private company, it would be handled by an agency of the Federal Government.
36. Instead of meeting the problem as individuals, all medical costs would come out of this national fund. The exact manner of payment would be determined by the medical profession itself.
37. First of all it would provide complete family-doctor service. Instead of paying the doctor on the spot, as now, he would be paid out of the insurance fund. You and your family could afford a physician at all times. Illness, instead of being neglected, could be attended to properly and in time.
38. The medical insurance fund would also pay for surgery and for specialists.
39. It would pay for hospitalization—up to 60 days a year.
40. Nursing care would also be paid for—as directed by the doctor.
41. X-ray and laboratory costs—this is also provided for as part of the plan.
42. Dental care for the whole family. This too, would be covered by the health insurance system. The amount of service would depend on the number of dentists available.
43. Payment for eye care and eyeglasses is also included. In short, complete medical coverage necessary to protect and maintain health.
44. The answer is: Approximately 85 percent of the population—or nearly everyone in the country.
45. The workers.
46. Farmers and farm workers.
47. Professionals, such as teachers, lawyers, clergymen, and the like.
48. The self-employed—like this shoemaker, and other small business people.
49. How much would it cost? That is an important question about which there has been a great deal of confusion.
50. National health insurance would be financed by a 3 percent pay-roll tax. One-half to be paid by the wage earner; the other half by the employer. It would be paid for in the same way as the present social-insurance deductions.
51. For example, if this man earned $44 a week, he would pay approximately 66 cents a week into the insurance fund for complete medical coverage for himself and his family.
52. This shoemaker, as a self-employed person, would pay the entire 3 percent on an income up to $3,600 a year, himself.

insurance
and old-age

sponsibility
ceiving the

uld lead to
e National
ssociation,
n of patient

l to choose

refusing or

How would
town, and
and funds

f the public
al officials,
the Nation.
perating as

tically also
d patients.
ar opinion,

perous year
front com-

75. The fact is that after many years, only 3 to 4 percent of the people are now covered by private voluntary medical plans. It's an old jalopy that can only accommodate a few. In most cases, these plans are too expensive for lower income groups and do not provide both hospitalization and all around medical care.
76. National prepaid health insurance is a method of removing the economic barrier which prevents the majority of the population from obtaining adequate medical care and health protection. While adoption of this plan would be a big step forward, we must be very clear that it is not a panacea—not a cure-all by itself. There are other barriers that also need to be removed.
77. We need more hospitals. Many more. At present some 15,000,000 people live in communities which have either no local hospitals, or else hospitals far below decent standards. In other places, hospitals are greatly overcrowded This situation is particularly serious in rural areas.
78. We need more public-health centers like this one. Did you know that 40,000,000 citizens of the United States live in communities lacking full-time public health services. Absence of these facilities is a hazard to health.
79. We need more research. More funds to investigate the causes, prevention and cure of illness now afflicting us. We need to end discrimination in medical education to allow persons of all races and faiths to enter this vital field of human service.
80. Above all we need a decent standard of living, so that everyone is well-fed, well-housed, and well clothed—for, after all, is not that the foundation for good health?
81. Meanwhile, removal of this barrier, would, as the late President Roosevelt advocated, give the American people "the right to adequate medical care."
82. Adoption of prepaid health insurance along the lines of proposed in the National Health Insurance Act is a democratic and cooperative way of solving one of the major and immediate health needs of the Nation.
83. We started off by saying the the most precious possession of a country is its people. The National Health Act is a means of bringing good health to the present generation and guaranteeing it for future generations. And let us remember, a healthy people makes a healthy nation.
84. The end.
85. Credits.

ACKNOWLEDGEMENTS

We wish to acknowledge with thanks the generous assistance and cooperation of the staff members of the Committee for the Nation's Health in supplying data and valuable advice.

Some of the material used in the film is adapted from the pamphlet Health Care for Americans, by C. E. A. Winslow, published by the Public Affairs Committee, Inc.

Photos used in this film strip are from the Library of Congress, Federal Security Agency, United States Public Health Service, Farm Security Administration, OWI, and Underwood & Underwood, and New York City Public Library.

REFERENCES

Health Care for Americans, by C. E. A. Winslow Public Affairs Committee.
Health for the Nation, Michael M. Davis, Survey Graphic, December 1944.
Principles of Nation-wide Health Program. Report of the Health-Program Conference. Committee on Research in Medical Economics, 1790 Broadway, New York 19, 1944.
Medical Care in a National Health Program. An official statement of the American Public Health Association. American Journal of Public Health, December 1944.
Is Your Health the Nation's Business? EM 29, GI Roundtable, War Department, Washington, D. C., January 1946.
Medical Care Insurance—A Social Insurance Program for Personal Health Services. Report from the Bureau of Research and Statistics Social Security Board, 1946.
National Health Act of 1945—Need for Medical Insurance. A memoranda prepared by Bureau of Research and Statistics, Social Security Board, Washington, D. C., 1946.

Further information regarding national health insurance may be obtained from the Committee on the Nation's Health, 1790 Broadway, New York 19, N. Y., and the Physicians Forum, Inc., 510 Madison Avenue, New York 22,N. Y.

d at this
Monday,

ance, now
ust issued

ts on the
lth condi-
tional In-

esearch in
an inter-
he layman

nd social

nes. Run-
ration and
ined from
from Cur-

er?

ion with

Senator DONNELL. You understand, however, as a matter of your own knowledge, that the Daily Worker is a Communist publication? Is that correct?

Dr. DAVIS. Yes.

Senator DONNELL. I now offer this in evidence for the record.

Senator SMITH. You don't want to offer the whole paper, do you?

Senator DONNELL. Just this excerpt.

Senator SMITH. Just the excerpt?

Senator DONNELL. That is correct. I offer that into the record.

(The clipping referred to follows:)

NEW FILM STRIP DRAMATIZES NEED FOR HEALTH INSURANCE

America's health problem and the question of national health insurance, now the topic of Nation-wide discussion, is the subject of a new film strip just issued by Current History Films, 77 Fifth Avenue, New York City.

The film, entitled "Medical Insurance—Pathway to Health," puts on the screen, in a new visual style, the facts and figures on America's health conditions and dramatizes the proposals contained in the controversial National Insurance and Public Health Act, introduced into Congress May 20.

In a simple, straightforward manner, it boils down reams of research in medical economics and thousands of pages of professional writing into an interesting series of hgihly graphic illustrations and pictures which give the layman a quick grasp of an involved technical subject.

The film is excellent for discussion and current events groups and social studios classes.

Medical Insurance—A Pathway to Health tells its story in 83 frames. Running time with narration is 17 minutes. The most complete with narration and documented background material is $2.60 postpaid. It may be obtained from the IWO Film Division, 80 Fifth Avenue, New York City, or directly from Current History Films.

Dr. DAVIS. Might I ask, Mr. Chairman, on that point, as to the relevancy of this discussion. I am very much puzzled as to its relevancy. The Committee for the Nation's Health——

Senator DONNELL. The relevancy——

Dr. DAVIS. Might I finish my statement, please?

The Committee for the Nation's Health offers its services generally in any capacity in which it can furnish expert technical assistance on the subject matter, and I had not thought that we would be obliged to investigate the political background of an organization that asked us to review, for technical reasons, a document or a visual thing which they submitted to us with the request that we give them the benefit of our technical knowledge.

As far as I can see, we would have had to go into considerable research in order to get the background which you or your staff say it has developed on this case. I don't quite see how it can be expected that the Committee for the Nation's Health set up criteria of that sort before we are willing to give service on requests from any organization that comes to us for advice.

Senator DONNELL. Did you know who it was who brought in this film-strip narration? Do you have any recollection as to who it was?

Dr. DAVIS. I don't know.

Senator DONNELL. You don't know?

Dr. DAVIS No. He just came in.

Senator DONNELL. Do you know his connection?

Dr. DAVIS. No. It was no person I had ever been familiar with before. The name of the man who brought it in was no one I recognized at all.

the char
arration?
ver their

the relia-

ubmitted

s to who
em were?

e man or

nder such
ad never

signed to

he Inter-

anything

May 20." Would you refer to S. 1320 and see on what date S. 1320 was introduced in Congress?

Dr. DAVIS. May 20.

Senator DONNELL. May 20, 1947, is that right?

Dr. DAVIS. Yes.

Senator DONNELL. Does that not refresh your memory to the effect that the film strip was brought to you much later than 10 months ago?

Dr. DAVIS. It doesn't refresh my memory. As far as the Daily Worker is concerned, I never see the Daily Worker. I don't know that I have ever had a copy in my hand. It means nothing to me.

Senator DONNELL. Now I want to show you also another document, which is marked "Prepared by the Committee for the Nation's Health," entitled "Brief History of Health Insurance in United States." I hand you that document and ask that you look at it please, and tell me whether you ever saw one of those before, or if you don't recognize it, Mr. Louchheim, I see, is still here, and perhaps he would recognize it.

Dr. DAVIS. Do you recall this, Mr. Louchheim?

Mr. LOUCHHEIM. I recall, sir, that we were asked to prepare a brief history of health insurance in the United States. I have never seen this one, though.

Senator DONNELL. You have not seen that?

Mr. LOUCHHEIM. No.

At the same time these people came in and suggested that we look over that, they asked us for a brief history of health insurance in the United States. We had one, and gave it to them.

Senator DONNELL. It says the data were prepared by the Committee for the Nation's Health.

Mr. LOUCHHEIM. We have distributed a history of the health insurance movement very often. That was the same data, and they put it in that form.

Senator DONNELL. Who put it in that form?

Mr. LOUCHHEIM. The people who put it out.

Senator DONNELL. And who put it out?

Mr. LOUCHHEIM. I don't know.

Senator DONNELL. This "ERG" organization?

Mr. LOUCHHEIM. I don't know. I assume so, since you have the two together.

Senator DONNELL. Did you assist Mr. Davis in going over this film strip narration to which I have referred?

Mr. LOUCHHEIM. Yes, sir.

Senator DONNELL. You remember criticizing it?

Mr. LOUCHHEIM. I remember doing it.

Senator DONNELL. How long ago was it done?

Mr. LOUCHHEIM. I would say within the last 5 months.

Senator DONNELL. Within the last 5 weeks?

Mr. LOUCHHEIM. Five months.

Senator DONNELL. Within the last 5 months.

Mr. LOUCHHEIM. Yes.

Senator DONNELL. Now, Mr. Davis thought it was within the last 10 months. Are you sure whether it was subsequent to May 20 that you went over it?

Mr. LOUCHHEIM. No, sir, it was prior to May 20.

Senator DONNELL. It was prior to May 20, 1947?

ance Act”

opy of S.

rance and

f 1946.

nes of the

al Health
nd Public

last year,

n that bill
That ap-

Insurance
n the fact

Mr. LOUCHHEIM. At which time, in principle, we approved S. 1320.

Senator DONNELL. How did it happen that you were able to discuss it 11 days before it was introduced?

Mr. LOUCHHEIM. Because we received a blueprint from Senator Wagner's office.

Senator DONNELL. I want to ask you just one or two further questions.

Who was it who brought this film strip narration to your office?

Mr. LOUCHHEIM. You mentioned, I believe, the name of Roberts.

Senator DONNELL. You think it was Mr. Roberts?

Mr. LOUCHHEIM. Yes.

Senator DONNELL. That would be the writer of the script, Mr. Samuel Roberts, is that right? Or do you know?

Mr. LOUCHHEIM. I believe it was Mr. Roberts who came in.

Senator DONNELL. Was anyone with him?

Mr. LOUCHHEIM. No, sir. Just Mr. Roberts alone.

Senator DONNELL. How long did you gentlemen have this film strip narration in your possession?

Mr. LOUCHHEIM. We never had it in our possession. We looked it over and made certain suggestions and they took it back with them.

Senator DONNELL. You had just one conference with Mr. Roberts, is that right?

Mr. LOUCHHEIM. Just one conference with him, and then I believe he came back and showed us the strip itself.

Senator DONNELL. Do you remember what changes and suggestions both you gentlemen, or either of you, made to Mr. Roberts for incorporation in the film strip narration? Do you recall?

Mr. LOUCHHEIM. I don't know if he followed them out. I know there was this one section in which he dealt with the earnings of the physicians. He gave the earnings on a weekly basis, which I thought was very unclear. I don't know whether he still kept it that way.

Senator DONNELL. Did you give him the name "National Health Insurance Act"?

Mr. LOUCHHEIM. No.

Senator DONNELL. Do you know whether that name appeared in the film strip narration when it reached your attention?

Mr. LOUCHHEIM. I am pretty certain that it did not, and it was for that reason that I said there would be a new bill.

Senator DONNELL. I call to your attention this yellow paper which I handed you a few minutes ago, the concluding paragraph of which I read:

> The National Health Insurance and Public Health Act, 1947.
>
> The Wagner-Murray-Dingell bill, with the above title and in slightly revised form, was reintroduced into the Eightieth Congress. It is a blueprint of a comprehensive national health program and when adopted will become an extension of our American social security system.

Did you furnish this—which I will mark at this time as exhibit X for identification—did you prepare that document and give it to the same person, Mr. Roberts, to whom you referred?

Mr. LOUCHHEIM. We prepared that document at a later date from the time he came in and showed us the script. And we sent it to him. I did not hand it to him.

Senator DONNELL. You sent him this document, which I have marked as exhibit X?

began with
he medical
ital Service
seamen get

e plans for
these plans

h insurance
one branch
abor Legis-

f voluntary
sion of the

FIRST WAGNER-MURRAY-DINGELL BILL

In 1934, Senators Wagner, Murray, and Congressman Dingell introduced the first Wagner-Murray-Dingell bill, a comprehensive revision of the Social Security Act, including a broad national-health program, with national health insurance as its central feature. The other parts of the national-health program met no important opposition and Congress voted, and has continued to vote, additional grants for the extension of public health services and of maternal and child care. Congress also adopted in 1946 the Hospital Survey and Construction Act, carrying out that part of the program which related to the extension of hospitals and the establishment of new hospitals where needed, especially in rural areas.

SECOND WAGNER-MURRAY-DINGELL BILL

In 1945, the Wagner-Murray-Dingell bill was reintroduced into the Seventy-ninth Congress, with some changes. A little later the health provisions were separated from the general revision of the Social Security Act and introduced as a separate measure, the Wagner-Murray-Dingell National Health Act, S. 1606. Extensive hearings on this bill were held in 1946 before the Senate Education and Labor Committee.

TAFT HEALTH BILL

Shortly after the Eightieth Congress convened in 1947, Senator Robert A. Taft, Republican, Ohio, in association with Senators Smith, Ball, and Donnell, introduced a bill which he termed a substitute proposal for national health insurance as a solution to our Nation's health problem. This bill provides Federal grants-in-aid to States for charity medical care for the needy.

THE NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH ACT, 1947

The Wagner-Murray-Dingell bill, with the above title and in slightly revised form, was reintroduced into the Eightieth Congress. It is a blueprint of a comprehensive national health program and when adopted will become an extension of our American social-security system.

(Prepared by the Committee for the Nation's Health.)

Senator Donnell. I don't mean this specific paper, but the material contained in this exhibit X you sent to Mr. Roberts later on, you remember that?

Mr. Louchheim. Yes.

Senator Donnell. Did Mr. Roberts tell you what he was going to do with this exhibit X?

Mr. Louchheim. He said he was going to distribute it along with the film strip as background material for educational purposes.

Senator Donnell. Did he tell you he was going to advertise the film strip narration extensively?

Mr. Louchheim. I knew he was going to sell it for two-dollars-and-sixty-odd cents, so I assumed that he would try to sell it and distribute it as much as possible.

Senator Donnell. Did he tell you how extensively he was going to advertise it?

Mr. Louchheim. No; he did not. He did say that he wished it to be used in small groups and colleges, and so on. Our only interest in the matter was in giving him material, and we do give material to all organizations and all people coming in and asking for material.

Senator Donnell. Did you see this article in the Daily Worker of June 2, telling about this film strip narration?

Mr. Louchheim. I have seen no article in the Daily Worker at any time.

Senator Donnell. I want to show you also, Mr. Davis and Mr. Louchheim, another document entitled "Federal Security Agency,

narizing
e Social
ovides a
d of the
tes that
cured in
Security

f you has

it? Do

e seen it.

et there?
see, June
fice when

aper dis-

ute docu-
ments.
had any-

Dr. Davis. I should like to state this very frankly. I do not wish to be discourteous, but I believe I am entitled to express an opinion on this. This seems to me like an effort to include the Committee for the Nation's Health activities in Communist activities. It seems to me that that is entirely irrelevant as well as being untrue. The program which the Committee for the Nation's Health is advocating is essentially the program which has been recommended twice to Congress by the President of the United States. It has also been advocated by a large number of other organizations.

The Committee for the Nation's Health happens to be an organization especially formed to promote or spearhead this. It seems to me not to be a satisfactory example of American procedure to infer that its advocacy of such a program is linked with a subversive un-American organization such as the Communist party. I should like to have that in the record as a statement of opinion.

Senator Donnell. Did you make any inquiry of Mr. Roberts when he brought you this narration for film strip as to his identity?

Mr. Louchheim. I did not in his case, nor in the case of hundreds of others who come to us requesting information. Hundreds of individuals have come to our office asking for information.

Senator Donnell. Did he tell you where his place of business was?

Mr. Louchheim. I don't believe he did, sir, although he must have given me an address to send the material to him at a later date.

Senator Donnell. And you did send the material to that address?

Mr. Louchheim. I did, sir.

Senator Donnell. Now, Mr. Davis, in the course of your discusssion of the bill you referred quite extensively to the Tom Jones illustration. I will not go into great detail on that. It is getting very late, and it is largely argumentative matter. But may I ask you this: I think you made some reference—at least there was some reference in my mind, perhaps you did not mention it—to the freedom of choice of physicians. Did you refer to that?

Dr. Davis. I did mention it. I think we all take it for granted as being a necessary and desirable thing.

Senator Donnell. You regard it as necessary and desirable?

Dr. Davis. Yes.

Senator Donnell. You are familiar with the fact that S. 1320 permits physicians in various localities of the country to determine whether or not the method of payment shall be by fees for services or on a per capita basis, is that not correct?

Dr. Davis. Yes, sir.

Senator Donnell. On page 20 of the bill reference is made to the practitioner's list. You are familiar with that provision, are you not?

Dr. Davis. Yes.

Senator Donnell. Let me ask you this: Suppose that in the place where Tom Jones lives there are three doctors, and that those three doctors have elected to avail themselves of the panel plan provided under this bill. Suppose to Dr. Jones there were allotted 500 persons—he has 500 names on his panel. Dr. Smith likewise has 500 names on his panel, and Dr. Williams also has 500 names on his panel. Suppose that Dr. Jones was generally considered the best doctor in the community, and as a result his panel of 500, when the opportunity was offered, was promptly filled, and 500 people came and asked for permission to go on that panel, and were granted it.

and asks
anything
es for the

er or not
f this bill
ve are not
uiry?
answered

omes after
s the man

Senator, it
tement as
rity to say
ome other
here is no

f patients
maximum
e various
rds, it sets
maximum
st be, from

mittee, they would explain to me that a limit had been set for my protection, so that the quality of medical service would not be impaired, and if that were properly explained to me I would be glad that I was not forced upon a doctor who already had as many patients as he could properly care for—I would be glad that there was such a limit set, and I would say, "Well, I guess I'm in hard luck then. I'll have to pick another doctor." That's all.

Senator Donnell. The point I am getting at is that there is not an entire freedom of choice of physicians by the patients under this bill.

Dr. Davis. I regard the limitation of choice under this particular section to be, in the first place, a limitation in the interest of both doctor and patient, and if you had no such provision in the law you would find in many areas that the local practitioners would do everything possible to get some kind of ruling that would enable them to set restrictions.

I say that for this reason: As I told you, I have been through this experience in connection with international health insurance, and I have also observed the work of public-health centers providing medical service to large numbers of indigent persons.

At one time in Chicago during the thirties I was on the advisory group. We had 400,000 people receiving care. And, Senator, what I am getting at is that the doctors themselves wanted the welfare department, and finally got the public welfare department, to set limits in order to protect themselves from the pressure that was put upon them by doctors who happened to be so popular, or because they were guaranteed a fee from the welfare department, which is exceptional, but you have to protect yourself from a few.

They wanted a limit set and limits were set, because the doctors insisted on it. So the county medical society advisory group under the public welfare department put it into effect, and I am saying that if you did not have this in the law you would find the administrative authorities under tremendous pressure to set up a limit for the protective of everybody concerned, and the limitation of free choice there is less of a limitation than we have today imposed by the economic limitation of most patients at the present time.

Senator Donnell. I will not take up much more of your time. I would like to question you, if we had time, in connection with these panels being made up at a given time, and you and I might get on Dr. Jones' list at that time and then 2 years after we might have a disease which we would like to have Dr. Williams treat instead of Dr. Jones, and Dr. Williams in the meantime might have his panel filled. We could discuss that at length, but I don't do that because of the lateness of the hour.

But I do want to ask you this: You do not anticipate that the fee-for-services plan would be used exclusively in this country if S. 1320 went into effect?

Dr. Davis. I would anticipate as far as general practitioners would be concerned, because there is a marked distinction there—I think that a great many doctors, especially in middle-sized and small communities, as soon as they appreciated the advantages of the per capita system, would elect that system by a large majority.

Senator Donnell. You would like to see the capitation system go into effect?

it would

e greater
em?
he value

Dr. Ernst

up except

operated.
sufficient
ere it can
you have
tra paper
certainly
t want to
e general

of admin-
e system
ns have a

as a consultant concerning their economic and public relations. I appear today as chairman of the executive committee of the Committee for the Nation's Health.

Mr. Louchheim has already made clear that this committee favors the National Health Insurance and Public Health Act, S. 1320. I will discuss some of the changes which appear in S. 1320 as compared with S. 1606, the bill on which extensive Senate hearings were held last year. I will deal with some objections which have been raised to S. 1320 and will contrast it with the Taft-Smith-Ball-Donnell bill, S. 545.

Too often both friends and critics of the National Health Insurance and Public Health Act talk about the provisions of the bill from the top down. It's much easier to understand them from the ground up.

HOW HEALTH INSURANCE WOULD WORK

How would the bill work for Mr. Thomas Jones, a textile mill worker who lives with his family in the town of Roanoke Rapids, N. C.? Tom Jones comes home from work one day feeling flushed and achy. He coughs a good deal of the night and the next morning his wife thinks he ought to have a doctor. The health insurance law is in operation. Tom Jones earns $36 a week. He pays 54 cents a week, 1½ percent of his earnings, into the national health insurance fund. His employer pays an equal amount.

Now that Tom Jones is sick, how does he get a doctor? Does he have to write to Washington or ask a local official? No. Tom Jones calls the doctor he had had before the law went into effect. Dr. Brown comes to see him, just as he would have come before the law was passed, but with two important differences. In the first place, Tom Jones won't get any bill from Dr. Brown. In the second place, Dr. Brown can prescribe what Tom needs and not just what Tom can afford—laboratory tests, for instance, or a specialist in Tom's illness proves obscure or takes a bad turn. Dr. Brown will be paid by the health insurance official of the area that covers Roanoke Rapids and Halifax County in which this town is located.

Where does the Federal Government come into all this? Not at all. The National Health Insurance Board would have paid North Carolina its quota from the national health insurance fund. North Carolina would have allotted the Halifax County health-service area its quota.

Suppose Dr. Brown thought Tom Jones had pneumonia, that he had a poor heart and might be in danger. Tom Jones or his wife, if they were anxious, or Dr. Brown, if he thought it necessary, could call in a specialist, Dr. George Johnson, the one internist within reach. Either of these doctors might decide to ship Tom at once to the Roanoke Rapids Hospital where he could get better care than Mrs. Jones could give him at home. The local health insurance fund would pay this hospital the costs of its services to Tom Jones.

In all this, neither Tom Jones, nor Dr. Brown, nor Dr. Johnson, nor the Roanoke Rapids Hospital would have anything to do with any official or board outside of Halifax County.

Suppose Mr. Jones was dissatisfied, and complained that Dr. Brown had delayed 24 hours making his first call and then was hasty and disagreeable. A local officer or committee would reach some decision about this complaint. Hearings and appeals could be had if demanded. Suppose the trouble were between Dr. Brown and Dr. Johnson, the specialist believing that Dr. Brown had made an unpardonably bad diagnosis when he finally did get around to calling on the patient. This being strictly a medical dispute, it would be dealt with by a committee composed wholly of physicians.

Where would the Federal Government come into all this? Not at all.

How and how much would Dr. Brown and Dr. Johnson be paid? Dr. Brown, being a general practitioner, would be paid by the method which the majority of these practitioners in Halifax County voted for. If, however, Dr. Brown or one or two of his colleagues wanted to be paid differently, for example, a salary on whole or part time instead of by fees, these doctors would have the right to negotiate this method of payment with the Halifax County health insurance agency.

How would the fee or salary rates be determined? The State health-insurance agency would have worked out a fee schedule with the State medical society. This schedule, however, would be flexible enough to be adapted by local health-service areas to their particular conditions. There would be no uniform national schedule of fees, of capitation rates, or of salaries for doctors.

e whether
pecialists?
laid down
advisory
rds of our
rds would
ized as a
ke Rapids
alth-insur-
e the say
o have to
l hospital
aid out of
e that Dr.
medicine.
ederal Se-
ng of Tom
ary of the

for them
ll because
ocal areas.
sure State

nal health
the States
planning

out for State and local administration are just a smoke screen to hide a grab for power by a Federal bureaucracy. This charge is nonsense. In the first place, the six Senators and two Representatives who have introduced this bill into Congress were not born yesterday. They are certainly familiar with the universal objection that would arise from the American people if so personal a matter as medical care were attempted to be run by directives at long range. As practical men, they and every other sensible person know that it would be wholly impossible to run medical services at long range, or to have any uniform administrative pattern defined by national authorities for all parts of this great and varied country.

MAINTAINING STANDARDS

In the second place, the bill nowhere gives the Federal authorities power over State and local administration. It does give Federal authorities the power to make and enforce certain standards. Some of the standards are stated in the law itself; some would be defined in regulations. From their nature, national standards must be in general terms. They must be adapted to differing local and State conditions, by State and local authorities. Having the power to require that hospitals' and physicians' services in every State shall meet certain general standards before these agencies and individuals may receive Federal funds is an entirely different matter from having power to control State and local administration.

As an illustration, take the emergency maternity and infant-care program administered during the war with Federal funds by the Children's Bureau for the wives and infants of servicemen. As you all know, many millions of dollars were spent in this program. The Children's Bureau was empowered to require and did require that Federal funds should be paid only to physicians possessing qualifications for the services which they would be called upon to perform. The Children's Bureau required that the hospitals in which the wives and children of servicemen were cared for must comply with certain standards. Of course, the Children's Bureau utilized, as S. 1320 calls upon the Federal authorities to utilize, the standards in such matters laid down by the appropriate and already existing professional bodies. Did the Children's Bureau take part in or interfere with the administration of the hospitals in which these women and babies were cared for? Did it attempt to direct the doctors diagnosing and treating them? Of course not. What would have happened to the Children's Bureau if it had tried to do this?

Again, the Veterans' Administration is now paying out Federal funds to hospitals and physicians on an immense scale in its home-town-care plan for veterans. The hospitals and the physicians must meet appropriate standards before they can be paid for the care of these veterans. But the Veterans' Administration does not direct the local doctors or interfere in the administration of the local hospitals which it utilizes in this program.

I use the illustrations to bring out the vital difference between defining general standards and administering services. Under S. 1320, the Federal Government would have something to say about standards, but it would not administer the services or pay the doctors and hospitals that provide them.

Should the Federal Government have anything to say about standards? The sponsors of S. 545 say "No." This view, however, is not shared by the two expert professional bodies which have testified before this committee, the American Public Health Association and the American Public Welfare Association. These bodies are composed largely of experienced administrators who moreover view these matters more from the State and local than from the national level. They regard the lack of Federal standards as a major deficiency in S. 545. One of them called it "unprecedented" in Federal-State programs.

The Senators will also recall that that distinguished body, the New York Academy of Medicine, declared forcibly in its testimony before this committee that absence of any Federal standards in S. 545 is a serious defect. Federal funds for which the Federal Government is responsible are to be paid to States and localities to support medical services to the people. Health programs using Federal funds should include certain standards with which States and localities must comply before they can get these funds. The New York Academy of Medicine states: "Without minimal Federal standards and the right of the Administrator and the Director to inspect and determine whether such standards have been met by the States receiving Federal grants-in-aid, the bill could result in lowering the level of medical practice."

e opponents
us Federal-

A board of
he Federal
d therefore
1320, how-
al Security
binet officer
alth Insur-
ctly to the
velfare and
the Board

Committee
r with the
tment to be
cation, and
senting the
is involved

predecessor
nning with
seamen and
e Treasury
ecretary of
y of living
ice or with
Service was

services and medical education are under lay control. The American Medical Associaton was largely responsible for the great reform in medical education during the decade beginning in 1910. An essential part of this reform consisted in transferring the ownership and control of a great many of the medical schools from the hands of the doctors on their medical faculties into the hands of lay boards of trustees. Practically all of our medical schools today are under boards of trustees composed entirely or almost entirely of nonmedical men.

Again, consider our voluntary hospitals, which provide the large majority of the general hospital beds in the United States and are one of the American accomplishments to which physicians, hospital administrators, and civic leaders point with pride. The control of voluntary hospitals is not in the hands of physicians but of laymen, usually lay boards of trustees, city, county, and State hospitals are likewise controlled by lay boards or officials. Not more than 5 percent of the hospital beds in this country are in institutions owned and controlled by physicians, and the number of hospitals of this type is diminishing year by year.

I might quote here, for the record, a statement of general principles of hospital organizations, adopted by the trustees of the American Hospital Association over 20 years ago and still not only valid in principle, but actually observed in the great majority of our hospitals.

GENERAL PRINCIPLES OF HOSPITAL ORGANIZATIONS

As stated by the trustees of the American Hospital Association, 1924. Reference: Proceedings of the American Hospital Association (1924), page 467:

1. *Unified governing authority.*—The hospital should have a single governing authority, a board of trustees, with complete power over the management of all branches of the institution.
2. *Composition of board.*—(*a*) The board of trustees should be composed of public-spirited persons, representing varied community interests. (*b*) Members of the professional staff of the hospital should not be members of the board.
3. *Unified medical responsibility.*—There should be a medical staff which should have the entire responsibility for the professional care of patients.
4. *Unified administrative authority.*—All administrative authority over all departments of the hospital should be vested by the governing board in one executive officer.
5. *Medical staff.*—The appointment of the medical staff should be vested in the board of trustees.
6. *Relations of staff and board.*—Representatives of the staff should meet with the board or representatives from the board at regular intervals.

Does lay control of a medical organization mean interference by laymen in medical matters? Not at all. If it did mean that, American hospitals would be battlegrounds instead of partnerships. The doctor's job is the diagnosis, treatment, and prevention of disease. That is what he is trained for. Lay boards do not tell doctors how or when to operate or prescribe.

In a hospital, a medical school or a voluntary health insurance plan run by its members, the lay board owns the property, manages the finances, appoints the medical staff, and authorizes the policies and the standards of the organization. The appointment of the staff may require selection among medical men. The authorization of policies and standards, including professional standards, always requires the advice and guidance of medical men. This advice and guidance concerning personnel and standards, the lay board gets from its medical staff. But the lay board has responsibility for final decision. In many instances the lay board is the disinterested and welcome arbiter among a group of staff physicians who are in private practice and in financial competition with one another. The standards of our hospitals would not be enforced half so well if the physicians instead of a lay board had the final control. Those who want evidence of this can find plenty of it. Above all is the major fact that it is upon this system of lay control that our American medical institutions have grown great.

This principle justifies the establishment of an administrative board which may include a majority of laymen, as in S. 1320. It justifies the placing of the whole system under a Cabinet officer, who will represent the whole public rather than the interests of a profession. It also justifies two other important requirements of S. 1320: On the one side, that issues, complaints, and other matters wholly concerned with the technical questions of medicine shall be settled wholly by physicians; and on the other side, that advisory and administrative bodies, except those wholly confined to technical questions, shall contain a majority of public representatives.

and county
system by
n of S. 545,
f organized
nedical-care
States the
ng a State

s, it seemed
uld be well
experience
nonopolistic
ning Froth-
t Attorney-
n Washing-
othingham's
his commit-
s testimony.

the practice
erican citi-
edicine has
prepayment
groups, as-
ith private
rvices.' He
lly increase
reasons for
the policies
ficials who

of plans organized under the auspices of other organizations and successfully maintained, many for a long period of years.

Whereas there are 90 medical society health-insurance plans described in this pamphlet, there are 175, or nearly twice as many, voluntary health-insurance plans under industries, unions, cooperatives, and other auspices. The membership of the medical-society plans is estimated at approximately 5,000,000. The membership of the 175 other plans is about 2,300,000.

Now, most of these 175 plans provide comprehensive medical service, that is, the services of general physicians and specialists in the patient's home and the doctor's office, as well as in the hospital.

Here we have it. The plans organized by medical societies offer only limited services, but the plans which have been organized by the people who pay the bills supply comprehensive care.

Why have not the plans organized by the people grown more rapidly in number and membership?

The chief reason is that the State and county medical societies, with the support of the AMA, have put every possible obstacle in the way of prepayment medical plans except those run by medical societies. The medical societies have made it uncomfortable for doctors who joined such plans. Sometimes they have expelled doctors who joined them. Furthermore, in about 20 States, the medical societies have recently caused laws to be passed which give special advantages to plans organized by medical societies and which, in some States, actually prevent any other plan from being organized.

PLANS RUN BY THE PEOPLE

Study the contrast between the medical-society plans and many of the voluntary health-insurance plans which are sponsored and controlled by the people who pay the bills. Some of these plans have been established for many years in large, well-known industrial establishments. One, for instance, has been operating for a long time in Baton Rouge, La. It covers about 15,000 persons, employees of the local plant of the Standard Oil Co., and the members of their families. The plan was started over 20 years ago with the cooperation of the company, which helped in financing the clinic building. But the plan is maintained entirely by voluntary pay-roll deductions from the workers and is managed by a committee in which both management and employees are represented, with a majority of employees. This situation is typical of a considerable number of well-established industrial health-insurance plans offering comprehensive medical and hospital services, and providing this service through group medical practice.

This method of organization has evolved as a result of experience, because when the people who pay the bills and receive the services for themselves and their families are in control, they have a direct motive toward financial economy. It's their own money that is at stake. They also have a motive to maintain and expand good service. It's the health of themselves, their wives, and children that is at stake. Much is said about the abuse of insurance plans by subscribers, especially if comprehensive services are offered. When the members themselves control the plan, they have a motive to check abuse, because abuses waste their own money. No pressure against malingering and other abuses by subscribers is more effective than pressure upon the the abusers from their fellow members.

BUDGETING MEDICAL COSTS

I wish now to take up some ideas which seem to be excessively popular among the opponents of S. 1320. One of these is the bogey of "socialization." At the beginning of these hearings, the senior sponsor of S. 545 said that people ought to pay for their medical care just as they do for their food, shelter, and clothing and that if we start socializing medical care, we will find that only a step toward socializing the other parts of our economy.

Of course, people should pay for their medical care. Paying for what we need is always better than having things given us. What I point out, however, is that paying for medical care stands on a different basis from paying for food, shelter, clothing or any of the other necessities and comforts in the budget of American families. Sickness costs are unpredictable as to when they will happen and how much they will be. You can plan your expenses for your food, rent, clothing, and every other commodity or service you buy, except one. That one is sickness costs. You cannot budget sickness costs in advance.

ch reason,
for Mr. and
n whatever
, either on
rest of our

at national
l deduction
it is a tax
v is a tax.
also insur-
y them to
one cannot
o. Spread-
he essential
ough which

as been "a
s to repeat
t their in-
only a few

te: "In the
de the field
statement,
money paid
ureaucrats.
payrollers

PROPAGANDA AGAINST HEALTH INSURANCE

Those who charge that there is organized propaganda in favor of national health insurance must admit that these identical attacking editorials suggest that somebody has organized propaganda on the other side. Who supports the writer whose brain-child is multiplied thus in the free press of America? I do not know. I do know that the National Physicians Committee states that they have a public relations staff which sends out material to a list of several thousand newspapers and periodicals. So maybe these editorials merely prove that the National Physicians Committee finds a market for some of its canned goods.

Health insurance in foreign countries is charged with a long list of other evils—poor quality of medical care, for instance, and promoting an increase of sickness. Some of these charges are based on phony statistics, or misuse of statistics. Some of them are stories of particular cases which are presented as if they were universal cases. These misstatements and exaggerations are repeated over and over again in the medical journals and in the pamphlets written by their public relations men. These pamphlets are circulated to our newspapers with the authority of organized medicine behind them and of course no refutations made by people who know the subject ever catch up with them.

If there were time, I would give examples, such as two well-intentioned articles by an American newspaper correspondent in New Zealand, published late in 1945 and since then enormously misused.

Last month the Woman's Home Companion published an article scare-heading unnecessary operations by American surgeons. This article and the full-page newspaper advertisements about it have been read by millions, but does anyone take it as representing the bulk of American surgery? No; we understand that the article describes certain abuses in our system of surgery which needs remedy. Now suppose the British Medical Journal published an editorial damning American surgery as a whole on the basis of this article. That would be what many of our medical journals have done, with less evidence to the British health-insurance system.

The big outstanding fact about health insurance abroad is that health insurance has grown for two generations in countries of all sizes, kinds, and political complexions; that it has extended in the proportion of the population covered and in the scope of services rendered; and that neither the people nor the doctors of these countries would think of abandoning it. The British Medical Association opposed the enactment of national health insurance in 1911; but after experiencing its operation for 16 years, representatives of the association testified before a committee of Parliament that national health insurance had improved the medical care of the British people and the condition of the British medical profession. Not 10 American doctors out of a hundred know this, because the medical journals they read have never told them.

In 1943 the Canadian Medical Association officially approved the principle of compulsory health insurance, expecting that it would soon be incorporated into national legislation in their country. I did not see one word about this action in any official medical journal in the United States. Just think what would have been published if the Canadian doctors had taken action the opposite way.

Think also what has happened since the war in the western European countries, the democratic countries. All these countries were impoverished by the war and all of them except Britain and Sweden were occupied and more or less looted by the Germans. Yet despite their impoverishment all these countries are extending their health-insurance systems, and the medical professions of these countries are cooperating with the governments in the process. Certainly, these facts are evidence that health insurance has not been a "failure" but, on the contrary, that it has been serviceable to the people's health and to the national economy. In Britain the extended national-health program was put before the country in 1944 by Mr. Winston Churchill's government. Certainly, that is evidence that the program was not the outcome of "radicalism."

Here is a report published last March by the United States Public Health Service, describing these recent developments in six of these countries. If the picture had been unfavorable, it would have been gleefully publicized in the medical journals. But it gives an encouraging picture; and so far as I have seen, the medical journals have printed nothing about it at all.

eign coun
it the fact
ing health
experience
ly and not

ne remarks
ot of scare
insurance
najority of
e annually
ler the bill
substitute

n the May
e of family
evels. The
e, the less
ppily it is
ar (20 per-
care. The
bout 4 per-
eople spent

vould be a
of $3,600 a
or 1½ per-
alf. Even

These plans are precisely the type which organized medicine has most strongly opposed. This type of plan might be wiped out by the medically controlled administrations which S. 545 would set up and by this bill's failure to include any antimonopoly provisions. Certainly further development of this type of plan would be stopped by S. 545. Under S. 1320, on the other hand, existing plans of this type would be protected and new ones could be started by either laymen or physicians, or by a body including both.

May I, in conclusion, summarize the reasons why the Committee for the Nation's Health supports S. 1320 and opposes S. 545.

REASONS FOR SUPPORTING S. 1320

We support the National Health Insurance and Public Health Act for these reasons:

1. It would assure the people of the United States that they can get doctor and hospital services without having to worry about sickness bills. Studies demonstrate that this is what millions need. Opinion polls show that this is what millions want.
2. It would enable people to pay regularly for these services in a self-respecting way, without charity and in proportion to their ability to pay; and, by utilizing the people's existing expenditures for medical care, would minimize new financial burdens upon taxpayers.
3. It would place the Nation's financial strength behind the States in caring for the indigent and in providing expensive special health services and facilities.
4. It would guarantee continued professional freedom and greater economic stability to physicians and hospitals.
5. It would recognize private effort but would prevent control by private interest.
6. It would place a national floor under standards of service and finance but would give responsibility for administration to the States and localities.

REASONS FOR OPPOSING S. 545

We oppose the Taft-Smith-Ball-Donnell bill (S. 545) for the following reasons:

1. It would place the administration of National and State funds in the control of private interests, inviting medical politicians instead of public administrators.
2. It would require large staffs and high administrative costs for the means tests, unless these were laxly applied or their income limits were high, in which case many times the money would be required than is envisaged by the authors of the bill.
3. The Federal administrative organization which it proposes violates sound principles and well-established precedents, at the evident behest of the American Medical Association and its allies.
4. It provides national funds for medical care without any assurance that these funds shall maintain high standards of care.
5. It violates States' rights although it makes a parade of emphasizing them.
6. It might practically destroy the United States Public Health Service and would certainly subordinate it under the control of organized medicine.
7. It would promote monopolistic control of voluntary-insurance plans by medical societies.
8. Its proposed aid to voluntary insurance plans is illusory because of insufficient appropriations.
9. It requires annual examinations of all school children, which competent authorities consider wasteful and unnecessary and which absorb funds that should be used for needed treatment of children.
10. It would start a program of dental care under the obnoxious charity principle, with present and prospective appropriations wholly inadequate to meet dental needs.
11. It would make public relief instead of medical service the basis of a national health program, forcing charity upon the self-supporting.

(Subsequently, Senator Murray addressed the clerk as follows:)

ARE,
25, 1947.

re,

nce in the
appear at

MURRAY.

NC.,
18, 1947.

transcript
1, Senator
ling a film
ory Films.
chnical in-
d you will
cers, dated
in reply.
ty to bring
nformation

and Sen-
Manasco,
us to send

FEBRUARY 21, 1947.

Mr. SAMUEL ROBERT,
ERG Productions, New York 3, N. Y.

DEAR MR. ROBERT: Under separate cover I am sending you Senate Committee Print No. 5 entitled "Medical Care Insurance." On page 52 you will find a table giving the distribution of physicians according to net income. You will note from this table that 40.7 percent of the nonsalaried physicians had net incomes of less than $3,000 during the year 1941.

Appendix B, starting on page 178, contains a detailed comparison of published studies dealing with the income of physicians.

The figures you quoted to me in your letter for the year 1929 are correct. In that year the average net income was $5,467 for physicians in private practice, however, as you know averages are overweighted by a few very large incomes. I believe, therefore, that it is more accurate to use the median figure instead of the average. The median net income in 1939 was $3,705. Thus in that year half the doctors had net incomes of less than $3,705, and half had net incomes of more.

I look forward to the opportunity of reading your script, and wish to assure you that our committee is anxious to be of every possible service to you.

Sincerely yours,

JOSEPH H. LOUCHHEIM, *Executive Director.*

ERG PRODUCTIONS,
New York 3, N. Y., February 18, 1947.

COMMITTEE FOR THE NATION'S HEALTH,
New York 19, N. Y.

GENTLEMEN: We are producing a film strip illustrating the need for prepaid medical insurance. One of the points covered is the income of physicians during prewar years. We were given some data on this but we are not positive on how reliable it is.

This is our information: "Taking a highly prosperous year, 1929, we find the following: The net average income of the American doctor was $102 a week. Half the doctors earned less than $75 a week and many had an income of around $50 weekly."

Could you help us by either confirming the correctness of these figures or giving us more authoritative ones. Please give us the source, also.

When our film is completed, and before we issue it to the public, we would like to have someone in your committee check it for accuracy. Could this be arranged?

Accept our sincerest appreciation for any cooperation you may be able to extend us.

Very truly yours,

SAMUEL ROBERT.

Senator SMITH. The meeting will stand recessed until the 23d of July at 9:30. It is impossible for the committee to meet this coming week.

(Whereupon, at 6:35 p. m., the subcommittee adjourned until 9:30 a. m., Wednesday, July 23, 1947.)

NIH LIBRARY
3 1496 00180 5368

~~AUG 26 1992~~